STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Broward Youth Treatment Center

Youth Opportunity Investment, LLC.
(Contracted Provider)
8301 South Palm Drive, Building #2
Pembroke Pines, Florida 33025

Review Date(s): August 6-9, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; or limited, unintentional, and/or non-systemic exceptions 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:

Gary Mogan, Office of Program Accountability, Lead Reviewer (Standard 1)
Tommy Henderson, Program Director, Eckerd Connect, (Standard 2)
Jennifer Jacoby, Sequel Youth Services, Regional Clinical Director (Standard 3)
Gabriel Medina, Office of Program Accountability, Regional Monitor (Standard 4)
Rondarrell George, Office of Program Accountability, Regional monitor (Standard 5)
Peter Keelan, Office of Education, Southeast Regional Education Coordinator (Education Services)

Program Name: Broward Youth Treatment Center
Provider Name: Youth Opportunity Investment, LLC.
Location: Broward County / Circuit 17
Review Date(s): August 6-9, 2019

MQI Program Code: 1269
Contract Number: 10553
Number of Beds: 40
Lead Reviewer Code: 149

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
4.01 Designated Health Authority/Designee *	
5.19 Youth Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	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

* 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 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

* 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 4: Health Services
Residential Rating Profile

Indicator Ratings

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

* 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 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

Program Overview

The Broward Youth Treatment Center is a forty-bed 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 overlay services (SAOS). In addition, the program fosters each youth by providing interventions as Thinking for a Change (T4C), Impact of Crime (IOC), Living in Balance (LIB) coupled with a gender-specific intervention utilizing the curricula Men's Trauma and Empowerment Model (M-TREM) and Talks My Father Never Had With Me. These treatment services provided includes individual, group, and family therapy practices. Program administration is comprised of a program director (PD), assistant program director (APD), clinical director, a registered nurse (RN), and a human resource manager. Case management services are provided by a director of case management, a transition services manager, and a recreational therapist. Mental health staff at the program includes a designated mental health clinician authority (DMHCA) who oversees three non-licensed clinical staff. In addition, the program has contracted psychiatric services with a licensed psychiatrist for the provisions of psychiatric services to all applicable youth. Medical services are offered from 6:00 a.m. to 6:00 p.m. seven days a week and are provided by a licensed designated health authority (DHA) and a full-time RN. Educational services 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 located in areas which are secured making youth access inaccessible. All meals are prepared on-site. Youth are divided into groups and rotate in and out of the dining hall as the area is not large enough to serve all forty program youth at one time. Program administration indicated the smaller groups are easier to supervise in this area and search before and after meals. The program has fifty-eight security cameras providing coverage with the capability to store video for up to thirty-days. All cameras were reported to be operational. At the time of the annual compliance review, the program had six vacant positions; four youth care worker I positions, a human resource position, and a transition specialist position. The program meets quarterly with their advisory board members who consist of community stakeholders. An interview with the PD indicated in the past few months, there has been a high turnover of staff. At the time of the annual compliance review, the program did not have any waiver of services granted by the Department. The program utilizes a trauma-informed care approach, taking into consideration their unique population of males with a history of substance abuse.

Strengths and Innovative Approaches

- Youth are permitted the opportunity to win GOTCHA incentives, which translates into “caught you doing something good.” Youth who are recognized by staff to win the award has their choice to pick a meal of their choice, receive longer telephone calls to family, or have an extended visitation.

- The program conducts quarterly in-house corporate reviews which allow staff the opportunity to win a corporate dinner, television gift cards, back packs, plus free trips and a guest to selected Florida locations.

- The program offers vocational training in the areas of forklift operation, culinary arts, cardiopulmonary resuscitation (CPR), and pro-tech vocation/technology course codes online which provide skills and knowledge needed to succeed in the highly competitive job market. The course further is utilized to improve communication and personal work place skills.

- To increase staff retention and employee morale; the program identifies an employee of the week, month, and year as well as conduct cook-outs and employee outings.

- The program incorporated an employee token system to recognize staff who demonstrate teamwork, leadership, and positive culture.

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 having unsupervised contact with youth. The program has a total of eighteen new staff hired since the last annual compliance review. A review of background screenings for each new employee verified staff received an initial background screening. Records reflected each new employee completed a pre-employee eligibility assessment with a passing grade. The program also 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 on each new hire 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 January 19, 2019, meeting the annual requirement. The Department of Education submitted an annual screening on January 19, 2019 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 are rescreened every five years from their initial hire date. The current contract was executed on May 15, 2016. There were no staff eligible for a five year rescreen at the time of the annual compliance review.

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 the 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. Seven reviewed staff personnel records reflected all staff reviewed the program's code of ethics and signed the acknowledgement form. The Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers were also observed to be posted throughout the program. A telephone located in the main hallway and cafeteria has been designated for youth to contact the Florida Abuse Hotline or the CCC, if youth feel they have been abused or neglected. It is a direct line and no dialing is necessary. At the time of the annual review, there were two CCC reports for physical abuse since the last annual compliance review. One was substantiated by the program, resulting in a written reprimand for staff. The second report was substantiated by the Department resulting in termination of the employee. There were no Prison Rape Elimination Act (PREA) investigations, one open Department of Children's and Families (DCF) investigation, no law enforcement, and no Office of the Inspector General (OIG) investigations pending at the time of the annual compliance review. Seven youth were interviewed and stated they feel safe in the program and staff are respectful when talking to them. Seven 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 seven interviewed staff were able to explain the process for allowing staff and youth to call the Florida Abuse Hotline or the CCC to report suspected abuse. An interview with the program director regarding staff violation of the code of conduct indicated an employee's misconduct may lead to immediate suspension or termination without regard to the order of disciplinary.

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 two incidents of physical abuse toward a youth since the last annual compliance review. A review of the reports indicated the program director (PD) took immediate action to address the concerns by removing the staff from youth contact prior to termination. The second incident is currently open while the Department of Children and Families (DCF) conducts their investigation. An interview with the PD indicated staff and youth are knowledgeable of contacting the Florida Abuse Hotline or the Central Communications Center (CCC). Staff are trained during the new hire training process and reminded at all staff meetings, supervisor meetings, and annually regarding appropriate interaction 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) within the required two-hour time frame. The program had a total of ten CCC reports for the past six-months. A random review of five CCC reports verified each were reported within the two-hour time frame and documented in the facility logbook and shift reports. A review of the program's internal incident reports and youth grievances reflected none should have been reported to the CCC. An interview with the program director (PD) 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 placed on no youth contact or administrative leave without pay pending the outcome of all investigations.

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 maintains a written policy and procedures related to Protective Action Response (PAR). The program has a PAR plan which was approved by the Department's Office of Staff Development and Training (SDT) on January 10, 2019. There were five PAR incidents documented in the program's hardbound notebook for the past six months. A review of the PAR incident reports found each was completed by staff trained to perform physical intervention techniques, completed by all staff involved on the same day as the incident to include the nature

of the intervention, date, and time. Mechanical restraints were not used in any of the reviewed PAR incidents. Each PAR report was reviewed by a PAR certified instructor or supervisory staff and determined the techniques used were approved by the Department. None of the PAR reports indicated the need for a PAR medical review. A post-PAR interview was conducted on each PAR report by the program director (PD) or designee within the required thirty-minute time frame from the incident. Each PAR report was reviewed and signed by the PD the same day as the incident and placed in a central file. The program's PAR rate during the annual compliance review period was 1.88, which is above the statewide Residential PAR rate of 1.59. An interview with the FA regarding the process for monitoring PAR incidents and use of force indicated, the PD is to have a discussion with staff in all staff meetings and shift briefings. If there is a youth who consistently gets into trouble, the youth is assigned to an administrative staff to ensure the youth receives help to prevent from being restrained. The clinical director and the management team will develop a plan to assist the staff with getting the youth in becoming compliant with program rules and practices. The PD further reported, the increase in PAR incidents over the past six months involved the same youth repeatedly not following direction.

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 written policy and procedures outlining the pre-service training requirements for newly hired staff. The program's policy reflected all newly hired full-time and part-time staff will receive a minimum of 120 hours of training which are computer-based and/or instructor-led topics and shall be completed within 180 days of employment. An annual training plan for pre-service training was submitted to the Department's Office of Staff Development and Training (SDT) on January 19, 2019 and approved by SDT on February 7, 2019. The plan outlines the program's required training hours, training objectives, course names, and descriptions for any instructor-led training. 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 program director (PD) indicated youth care workers are Protective Action Response (PAR) certified direct care positions and are included in the staff-to-youth ratios. All supervisors, program director (PD), assistant program directors (APD), 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. A review of seven staff pre-service training records verified each completed all required pre-service training requirements within 180 days of employment to include suicide prevention, emergency procedures, child abuse reporting, professionalism, ethics and standards of conduct, cardiopulmonary resuscitation (CPR), first aid, emergency procedures, Prison Rape Elimination Act (PREA), as well as the contract required training elements of stress management, restorative justice, universal precautions, behavior management, and gender-response. All reviewed pre-service training was entered in the Department's Learning Management System (SkillPro).

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

The program has a written policy and procedures outlining the in-service training requirements for program staff. The program has an annual training plan submitted to the Department's Office Staff Development and Training (SDT) on January 19, 2019 and approved by SDT on February 7, 2019. The plan outlined all Departmental required trainings as well as the program's required internal trainings. 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 program director (PD) indicated youth care workers are Protective Action Response (PAR) certified direct care positions and included in the staff-to-youth ratio. All supervisors, PD assistant program directors (APD), medical staff, mental health staff, case management staff, maintenance staff, and kitchen staff are PAR certified and are qualified to supervise youth in special circumstance. A review of seven staff in-service training records reflected all staff had supporting documentation to reflect their cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid trainings were up-to-date. Each reviewed record further verified completed training in suicide prevention, ethics, PAR, communications skills, professionalism, as well as the contract required training elements of stress management, restorative justice, universal precautions, behavior management. Records reflected four staff completed the contractual requirement of gender-specific response training while three staff records indicated staff did not complete the gender-response training in the calendar year 2018. Interview with the PD indicated the training was missed as an oversight. All staff records documented receiving sensitivity training on Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Asexual (LGBTQIA). Three supervisory staff training records were reviewed and indicated each completed in excess of the required eight hours of management training. All trainings were found to be documented in the Department's Learning Management System (SkillPro).

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

The program has a written policy and procedures to provide outlining a process whereby youth are permitted to submit a written grievance actions of the program, staff, conditions of the program, or circumstances within the program which are related to a violation or denial of their basic rights. The program has a three phase protocol which consist of an informal, formal, and appeal phases. Youth are informed of the grievance process during admission into the program. Grievance forms are available to youth in the dorm area and are located on the wall in a file holder next to the locked grievance box, which is accessible to all youth. Youth who have difficulty completing the form may receive assistance by staff on the instructions, preparing, and submittal of a grievance. The program had no grievances within past six months. For tracking

purposes, the program has a hardbound notebook divided into months of the year to monitor the date, type, and outcome of grievances submitted by a youth for a period of one year. A review of seven staff training records verified all staff successfully completed training for the grievance process. Seven youth were interviewed and all seven understood the grievance process and can ask for assistance if needed to complete the form. Seven staff were interviewed and were able to explain the program's grievance process. An interview with the program director (PD) indicated, the PD was able to explain the program's grievance process to include the three phases and timelines.

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

The program provides interventions and instructions focusing on the development of life and social skills of the youth and employs evidenced-based practices throughout a continuum of services provided within the program to decrease recidivism. The groups which covers life and social skills are Skill Streaming and Seeking Safety. The activities provided are campus tours, community service events, basketball games, football games, and chest tournaments which are played against other programs and high school students. The program conducts research to ensure interventions utilized in the program are standardized, validated assessments based on realistic research, and theory. The program treatment incorporates models which are cognitive-behavioral and based upon social learning theory and highlights skills and modeling of anti-criminal attitudes and behaviors. The program has a total of four clinical staff and two non-clinical staff trained in facilitating evidenced-based, promising practice, and/or practice with demonstrated effectiveness groups. Each clinical staff holds at a minimum of a bachelor's-level degree and non-clinical staff hold a high school diploma. Each of the sic staff have over three years of experience working with youth. A review of the program's activity schedule coupled with the group sign-in sheets and the treatment sessions table identified in the program's contractual requirements, reflected groups are held seven days a week and conducted by a qualified counselor. A review of seven youth performance plans verified at a minimum, one of the goals identified the need for youth to participate in one of the required group sessions. An interview with the program director (PD) indicated with regards to therapist, they are carefully chosen to deliver an intervention based upon their education and demeanor. If possible, youth with a parent/guardian who has a language barrier are matched with a therapist fluent in their primary language. Youth are matched to intervention groups based on their individual needs identified by the Residential Positive Achievement Change Tool (R-PACT).

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'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 identified from the Residential Positive Achievement

Change Tool (R-PACT). The program's primary discipline is substance abuse treatment. A review of the program activity schedule, handouts, and group sign-in sheets verified groups are held as required with majority of the youth's time spent in structured, therapeutic activities with a minimum of one hour of each youth's day devoted to the delivery of treatment services targeted to address identified risk, criminogenic behaviors, and treatment needs. The program has a total of six staff trained to provide service delivery. A review of six staff training records verified each of the six staff were trained to deliver life skills training. An interview with the clinical director indicated youth are provided skill training to deal with coping, anger, and creating a positive environment. Youth are provided the opportunity to practice these skills throughout the day, during family visitation, and when they attend outings outside the facility. Seven youth were interviewed and indicated the new skills they learned are listening, coping, communication, anger management, problem solving and understanding negative behavior. Each interviewed youth also stated they practice these skills daily.

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 clinical director 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 Tuesday's and Thursday's by staff trained to provide the service. A random review of seven youth performance plans and group sign-in sheets coupled with the program's activity schedule, verified the practice of restorative justice philosophy. Observation of youth in IOC training indicated the instructor delivered the curriculum as required. Review of seven staff training records indicated staff providing the service are trained in the curriculum.

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 program director (PD) and clinical director reflected when the program has enough males 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 also 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 PD confirmed each group session is held on Mondays and Wednesdays and facilitated by a trained staff. A review of the curriculum and the program's activity schedule indicated each addressing

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, 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 admissions either through an interview with the youth and/or supporting documentation within the admission packet. Alerts are then entered into the Department's Juvenile Justice Information System (JJIS), along with being added to the program's internal alert system. The internal alerts list is posted in master control, 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 can enter alerts when the youth is added, removed, and/or stepped down from precautionary observation (PO) or other mental health alerts. The medical alerts and food allergies, medical staff enters the alerts in JJIS and initiates the internal alert. The assistant program director (PD) and director of case management updates the youth with security alerts on the internal alert list and JJIS. A random review of seven youth healthcare records of youth with an alert entered in the JJIS system was reflected on the program's internal alert system. A review of the facility's logbook further supported the date and time a youth was downgraded and/or removed from an alert. An interview with seven staff indicated staff is 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 also a food allergy clip board in the meal preparation area. An interview with the PD indicated the department heads are responsible for entering and closing their alerts. The alert board is located in the conference room where briefings are held. 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 written policy and procedures for record management. The program maintains individual records for case management, healthcare, and mental health and substance abuse. A review of seven youth healthcare records, mental health and substance abuse, and case management records were observed to have been marked confidential. Each youth record is secured in the respective program office inaccessible to youth and identifies the youth's name, Department identification number, and date of birth. The case management records are also 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, and a miscellaneous section.

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

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 student 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 also held once a month with the youth in the program to ensure all issues are addressed concerning the youth. Agendas, sign-in sheets, and minutes are maintained in separate binders for both student council and town hall meetings. A review of the binders verified meetings are held as required. Seven youth were interviewed and indicated the program has a student council board for youth to provide input about what happens in the program. During a town hall meeting, youth can communicate a board member about a concern and the board member would convey it to the student council meeting to be addressed. An interview with the program director (PD) indicated youth can make recommendations for resolutions to issues they have during the town hall meeting or student counsel. An interview with three youth student council members indicated they can address their concerns and concerns of other youth in the program. They feel this process works because of the changes which have occurred in the program when brought to the program's staff attention.

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 program director (PD) 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. A review of the program's most recent

community advisory board members roster consisted of members of education, faith based, medical, Department of Corrections, a former youth, victim advocate, and law enforcement. The program does not have a member of the judiciary on the board; however, attempts to recruit continues. A review of the advisory board quarterly meeting agendas and minutes from the last annual compliance review verified meeting are held quarterly with the PD and advisory board members at the program. An interview with a board member was unable to be conducted during the annual compliance review week. Three community advisory board members were called for their input; however, there was not a return call. An interview with PD indicated the advisory board meetings are held quarterly at the program. The board make suggestions during the meeting 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 written policy and procedures to establish and utilize effective channels of communication among the program staff, corporate leaders, other agencies, stakeholders, and between youth and staff. The program conducts shift briefings, monthly staff meetings, monthly shift leader meetings, monthly management team meetings, and quarterly community advisory meetings to review and address pertinent information and follow up on program operations, health services, mental health services, case management, education, human resource, and support services. A review of the meeting minutes and agendas for each meeting verified they are held as required. An interview with the program director (PD) indicated in the past few months, there was a high turnover of staff. In order to increase staff retention and employee morale, the program identifies an employee of the week, month, and year, as well as cook-outs and employee outings. The program also incorporated an employee 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. Youth and parent/guardian surveys are conducted during visitation and upon the youth's release from the program. An interview with the PD indicated the outcome data used by the program are the parent/guardian exit forms, feedback during treatment team, and feedback during individual and family sessions. The PD further indicated the information received from the youth and parent/guardian surveys are reviewed and shared during manager's and all staff meetings and are incorporated into the program's planning process. Seven staff were interviewed and indicated staff meetings are held monthly. Two staff responded meetings are conducted daily. The topics which are discussed in the meetings are program matters, youth issues, alerts, incidents, and policy changes. One of seven interviewed staff stated they are briefed on the Comprehensive Accountability Reports (CAR), annual compliance reports, and youth and parent/guardian survey reports. Six of the seven interviewed staff stated they were not briefed on the reports and were unsure of the purpose for the reports. Seven staff were interviewed on how they believe the communication is amongst the staff in the program. Five staff stated communication is good, one stated communication is poor, and one responded communication is very poor.

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

The program has a written policy and procedures to ensure all employees receive a written performance evaluation. New staff are evaluated the first ninety-days of completed work and yearly; thereafter, on their job performances. Ninety-day performance reviews are rated on a scale of one to five with one being the lowest rating and five being the highest. An acceptable satisfactory rating is four to five. 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 seven staff performance evaluations verified staff are evaluated yearly and are 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 are filled and being performed as outlined in the job descriptions. An interview with the program director (PD) indicated the evaluation process for each staff is conducted the first ninety-days of employment for new employees and yearly; thereafter, for each staff position. A new employee will receive two evaluations within their first year and one evaluation yearly thereafter. Seven staff were interviewed. Four responded they receive a performance evaluation on a yearly basis, three responded every six months, and one staff responded quarterly.

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

The program has a written policy and procedures regarding recreation and leisure activities. These activities are geared to provide a range of supervised and structured indoor and outdoor recreation activities for the youth and shall be based on the developmental levels and needs of the youth in the program as well as youth input about their preferences and interests in various activities. According to the contract, the program is required to have a recreational therapist. The program filled the recreational therapist position on January 17, 2018. A review of the documentation reflected the recreational therapist has a bachelor's-level degree in recreation and sports management and has approximately five years of experience working with youth. The recreational therapist is responsible for planning, developing, and implementing daily recreation and leisure time activities designed to be physically challenging, educational, and constructive for the youth. A review of the documentation reflected recreational therapy activities are provided and are incorporated into goals on each youth's individualized treatment plan to participate in recreational activities. Each youth works with the recreational therapist to develop a Wellness Plan to achieve their desired goals while in the program. The program's activity schedule was reviewed and reflected recreation activity is conducted each afternoon for one hour. 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 are provided with at least one hour of outdoor recreation

a day. Further observation found a water cooler easily accessible for youth as a precautionary measure to prevent heat stress and/or dehydration. Seven interviewed youth stated they are provided physical and leisure activities for at least one hour each day. Each of the seven interviewed youth stated the program provides them with at least one hour of recreation and leisure time each day. Each youth reported they can play football, basketball, cards, soccer, run or lift weights, board games, puzzles, dodge ball, letter writing, and watch television during recreation and leisure time. Seven staff were interviewed and indicated the type of recreation and leisure activities provided to youth are basketball, football, dodge ball, kickball, 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 youth's parent/guardian by telephone and in writing regarding each youth's admission into the program. The program's policy also identifies procedures providing written notification to the youth's committing court for all youth admissions. Seven youth case management records were reviewed and each contained documentation indicating the youth's parent/guardian were notified by telephone within twenty-four hours of the youth's admission into the program. All seven case management records included documentation of the youth's parent/guardian being notified in writing within forty-eight hours of the youth's admission into the program and written notification to the committing judge and the juvenile probation officer (JPO) within five days of each 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 has written policy and procedures in place to ensure each youth was oriented to the program on the day of their admission. There were no admissions during the annual compliance review. Seven youth were interviewed and stated they received an orientation within twenty-four hours of admission and was able to explain the orientation process. An orientation checklist was used to explain and discuss the program's rules, schedules, and services available. Youth were also provided a copy of the program's youth handbook which includes information regarding services available, program goals, expectations, responsibilities and rules of the program structure, emergency procedures, daily goals, expectations, responsibilities and rules for youth to abide, emergency procedures, daily schedule, room assignment, search policy including which items are considered contraband, visitation, grievance procedures, the behavioral management system (BMS), dress code, hygiene practices, performance planning, anticipated length of stay, how to access medical and mental services, key staff and their roles, access to Florida Abuse Hotline, and access to the Department's Central Communications Center (CCC) for youth eighteen years of age or older. All seven youth signed the acknowledgment form to indicate their receipt of the youth handbook. Seven youth case management records were reviewed and each record contained documentation indicating each youth received an orientation on the date of their admission coupled with the youth handbook. Seven youth were interviewed and responded favorably they participated in an orientation process whereby all the program rules, procedures, and schedules were explained.

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.	

A review of three applicable closed youth case management records contained a written consent for youth over the age of eighteen years. The program has written policy and procedures to ensure written consent was obtained from youth eighteen years of age or older before providing or discussing the youth's physical, mental health, substance abuse assessments, and treatment with a parent/guardian or any other interested party.

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 written policies and procedures regarding a classifications process to assign youth a living and/or sleeping room on the date of admission. The program utilizes a classification system to promote safety and security for which a youth's classification is determined by their individual needs and identified risk factors. Seven youth case management records were reviewed and each contained an admission classification form which identified physical characteristics such as age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, aggression, suicide risk, medical risk, escape risk, and security risk of each youth. A review of the Department's Juvenile Justice Information System (JJIS) confirmed alerts matched the identified alerts utilized during each youth classification. The program's policy also indicates procedures for reassessments and/or reclassifications of youth to determine the risk eligibility for off-campus activities and participation in work projects or other activities involving tools or instruments. The program maintains an internal alert system documenting any medical, mental health, security risks, or special needs identified during the initial classification process or identified throughout the youth's stay at the program. Further review indicated room assignment were based on the youth classification. The program maintains a continually updated internal alert system documenting any medical, mental health, security risks, or special needs identified during the initial classification process or identified throughout the youth's stay at the program. An interview with the program director (PD) indicated at the time of the youth's admission, a classification meeting is held with the clinical director, case manager, and parent/guardian to gather information regarding a youth's risk. The information is shared with administration and a decision is made regarding room assignment. In some cases, youth are required to change their rooms due to interpersonal conflicts with peers or other risk factors.

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 a youth is a gang member or gang affiliated. Three applicable youth case management records were reviewed for youth being documented as a gang member. In each applicable record, the program notified local law enforcement and the youth's home county law enforcement in writing of the youth's gang status and current treatment program placement. All three reviewed records reflected and indicated the information was shared with the youth's juvenile probation officer (JPO), the Broward County School District, and documented in the Department's Juvenile Justice Information System (JJIS) as an alert. In addition, the alert was placed on the program's internal alert system.

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 written policy and procedures to ensure implementation of gang prevention is addressed during the youth's placement. Intervention strategies are provided when youth are identified as being a gang member or an affiliated gang member. The program utilizes the New Freedom/Phoenix Intervention Group as part of their gang prevention curriculum. Three applicable youth case management records were reviewed and identified goals included in each performance plan relating to gang intervention. Further review of group sign-in sheets verified each reviewed youth participated in gang prevention intervention training. Youth were screened during the admission process to determine if they were associated with gang or active gang members. Any youth displaying gang signs, paraphernalia, slogans, participating in any gang-related activity to include flashing gang signs, wearing gang colors, tagging, recruitment, and/or promoting a gang lifestyle will be identified and addressed by administrative staff and the treatment team.

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 an assessment of each youth using the Residential Assessment for Youth (RAY) tool is completed within thirty-days of admission and RAY re-assessments are completed within ninety-days after completing the initial RAY assessment. Seven youth case management records were reviewed. All seven records reflected each youth was assessed using a RAY assessment and/or the Residential Positive Achievement Change Tool (R-PACT), the Department's previous assessment tool, within the initial thirty-days of admission and were maintained in the Department's Juvenile Justice

Information System (JJIS). Seven youth case management records were reviewed and all were applicable for RAY re-assessments, which were maintained in JJIS, completed within ninety-days of their initial R-PACT assessment, and a copy maintained in each youth's case management record.

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

The program has written policy and procedure to ensure a Youth Needs Assessment Summary (YNAS) is completed on each youth in the program within the first thirty days of admission to the program. Seven youth case management records were reviewed and each contained a YNAS completed within thirty-days of the youth's admission and 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 to ensure the intervention and treatment team members including the youth, meet to develop a performance plan for each youth within thirty-days of admission. Seven youth case management records were reviewed for performance plan development. Each performance plan goal specified target dates for completion, the youth's responsibilities to complete the goal, and the program's responsibilities to enable the youth to complete the goal. All plans reviewed were dated and signed by the youth, intervention and treatment team leader, the treatment team members, parent/guardian when possible, and any other parties with significant responsibilities toward completing the goal. Each reviewed plan was developed within thirty-days of the youth's admission. The plans contained measurable goals developed by the treatment team and the youth, identified court-ordered sanctions, contained a transition goal to address their barriers for a successful release, included the responsibilities of the youth and staff, addressed the top three criminogenic needs, and identified target dates for completion. In each reviewed performance plan, the development of the plan involved treatment team leader, youth, parent/guardian, administrative representative, living unit representative, treatment team staff, educational staff, Department of Children and Families (DCF) staff when applicable, and was signed by all participants. Each of the reviewed records contained an electronic transmittal indicating a copy of the performance plan was sent to the youth's parent/guardian, juvenile probation officer (JPO), and committing court. All youth records contained the original performance plan, while a copy was provided to the youth.

Seven youth were interviewed on the treatment process. All youth interviewed understood the program's treatment process including the development of their performance plan, understood the goals on their plan, and received 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 revision of each youth's performance plan. The program treatment team may revise a youth's performance plan at any time a new need is discovered based upon Residential Assessment for Youth (RAY) re-assessment results, or when the youth has demonstrated progress or lack of progress towards completing a goal, and/or when newly acquired information is discovered. Seven youth case management records were reviewed and all were applicable for performance plan revisions. Each revision reflected the RAY re-assessment results, newly acquired/revealed information, and progress and/or lack of progress towards completion of the youth's performance plan goals. There were four youth applicable to the RAY re-assessments performed to facilitate transition activities during the youth's last sixty-days stay 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 committing court. Seven youth case management records were reviewed and four were applicable for ninety-day performance summaries. Three additional closed records were also reviewed, and all closed records contained supporting documentation the performance summary coupled with a discharge summary was completed and forwarded to relevant parties within ten working days. Each reviewed active youth record contained a performance summary completed within ninety-days of signing the initial performance plan and addressed the youth's overall progress with education, behavior management, levels of motivation, interaction with peers, adjustment in the program, and a justification for a request for release. Each summary was signed by the youth, treatment team leader, relevant team members, and the program director (PD). Supporting documentation indicated each applicable record contained a transmittal verifying a copy of each summary was forwarded to the committing judge, parent/guardian, and assigned juvenile probation officer (JPO). Seven youth case management records were reviewed and three were applicable for youth who were in transition. In each reviewed record documentation verified the original performance summary was maintained in the case management record, with copies forwarded along with the Pre-Release Notification (PRN) sent to the JPO within forty-five days of the youth's planned release. Each reviewed

record contained the signed and dated performance summary by all staff members including the PD. None of the summaries were requested to be forwarded in shorter intervals. Seven youth were interviewed, two reported they received a copy of their performance summary, three youth stated they did not receive a copy, and two youth did not provide a verbal response.

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 parent/guardian in the assessment process, progress reviews, formal treatment team meetings, and transition planning by virtue of supporting case notes documentation and copies of notification forwarded by mail. If parent/guardians are unable to attend the meeting in person, they are afforded the opportunity to attend by telephone, video conference, or provide verbal or written input prior to the meeting. Seven youth case management records were reviewed and each contained documentation advising the parent/guardian of the date and time of the performance plan development and treatment team meetings. Observation of treatment team during the annual compliance review reflected, the parent/guardian attended the meeting by telephone and was involved in the case management process. An interview with the program director (PD) indicated the program encourages parental involvement in case management process by inviting parent/guardians to treatment team meetings, visitations, family day, and family sessions. A review of the provider's contract, indicates the program is in compliance with improved family engagement and participation by notification to 100% of the parent/guardians of the importance of family involvement in the case management process. Seven 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. Records indicated the treatment consists of representatives from all areas of the program with an identified treatment team leader. The treatment team members consist of the youth, parent/guardian, juvenile probation officer (JPO), direct care youth counselor, gang prevention specialist, recreation therapist, the registered nurse (RN) from medical, clinical director, a member from administration, and a Department of Children and Families (DCF) case worker when applicable. Records reflected each representative participated in the case management process to ensure coordinated services are provided to each youth in the program. Seven youth case management records were reviewed and each contained documentation showing the required treatment team members actively participated in the case management process. Documentation also confirmed each youth's JPO was notified and participated in the team meeting by telephone. Observation of treatment team during the annual compliance review verified all members of the treatment team participated in the case management process. The annual compliance team member witnessed the team leader giving the youth feedback about 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 for the intervention and treatment team to reference or incorporate each youth's treatment plan into the youth's performance plan. Seven youth case records were reviewed and each youth had an educational plan, wellness plan, and career education plan incorporated into their performance plan. The reviewed seven youth records indicated all the records contained separate treatment plans to address medical, mental health, substance abuse, and developmental disability, when applicable. One youth was involved with the Department of Children and Families (DCF) who provided a care plan, which was also included into the youth's performance plan.

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

The program has a written policy and procedures to ensure the intervention and treatment team conduct a formal treatment team meeting every thirty-days and informal treatment team meetings biweekly to review youth performance to include a review on each youth's progress on their individual performance plan goals, behavior, individual treatment plan, as well as to review their Residential Assessment for Youth (RAY) re-assessment results. A review of seven youth case management records confirmed each youth had a formal treatment team meeting at least every thirty-days and an informal treatment team meeting biweekly with the required participants. All the case management records contained formal and informal treatment and team meeting documentation including the youth's name, daily review, all attendees, comments from treatment team members, brief synopsis of the youth's progress in the program, and performance plan revisions when necessary. Formal treatment team meetings included the treatment team leader, case manager, health services, mental health services, direct care staff, education staff, a representative from administration, youth, juvenile probation officer (JPO), and parent/guardian. Informal treatment team members consist of the treatment team leader, youth, and a minimum of one team representative. All youth case management records were reviewed and confirmed the practice of formal treatment team meeting taking place every thirty-days. The youth's JPO, parent/guardian, and other pertinent parties were notified by letter and/or email and were encouraged to participate in person, by telephone, or provide verbal or written input prior to the meeting. In addition, seven youth were interviewed and all indicated during treatment team meetings they could demonstrate and talk about the skills learned while at the program. Observation 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 program offers educational services through the Broward County School District. The program offers Type 2 vocational programming which teaches personal accountability skills to include but not limited to interpersonal communication skills, decision making skills, financial,

and literacy skills. These skills are both age and intellect appropriate as well as appropriate for employment seeking. The vocational programming provides an orientation to the various occupations which are directly related to the individual abilities, aptitudes, and skill levels. Course work includes résumé writing which summarized individual education and past work experiences, completion of job applications, as well as college application for those youth looking to further their education. The program offers vocational training courses in the areas of fork-lift operations, culinary arts, and pro-tech vocation/technology course codes online. The program also offers course work in marketing, finance entrepreneurship, and customer service. Each course is taught by a certified business education teacher. An interview with the program's lead teacher and program director (PD) verified the information indicated.

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 operates an academic program under the supervision and direction of the Broward County School District on a year-round basis. The youth are required to participate in educational and vocational career-related instruction for a minimum of 250 days during the calendar year with a minimum of twenty-five hours of instruction weekly. An interview with the program's lead educator indicated youth are provided twenty-five hours of instruction weekly with minimal interruptions. A review of the of the facility logbooks verified this practice. Seven youth were interviewed and asked if there were a lot of interruptions during educational instruction and one youth stated yes, while six youth responded there were not. The one youth stated yes, indicated there seems to be a lot going on all the time.

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

A review of three closed youth records confirmed each contained a detailed transitional plan based upon the youth's specific post-release goals identified at the youth's admission into the program. Each reviewed plan contained services and interventions based on the educational assessment, identified services to be provided during the youth's stay and upon release, and recommended educational placement for youth during post-release from the program. The transition plans were developed by the youth, the program's educational component, the program's counselors, and aftercare staff members with the expressed intent to develop specific plans for continuation of education and/or employment post release. Specific monitoring responsibilities of staff were also included in each plan.

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 to ensure a formal transition conference is conducted sixty-days prior to the youth's targeted release date. The transition conference meeting consists of the youth, treatment team leader, and program director (PD) or designee. The youth's juvenile probation officer (JPO), parent/guardian, Department of Children and Families (DCF) when applicable, education staff, and any other pertinent parties are encouraged to participate in person, by telephone, or provide verbal or written input prior to the meeting. During the conference, participants review transition activities on the youth's performance plan, revise the plan if needed, and identify additional goals if necessary. . Four youth case management records were reviewed for transition planning which confirmed documentation reflected a transition conference was held at least sixty-days prior to the youth's projected release from the program. In attendance were the youth, treatment leader, PD, and other connected team members. Each transition plan included appropriate goals and dates for the youth's release back into the community. All required participants were invited to participate in person, by telephone, or provide verbal or written input prior to the meeting. A copy of the plan was sent for return signature to individuals not in attendance. In each of the three closed records, documentation confirmed the youth and case manager was 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 to ensure an exit portfolio is assembled to assist each youth once released back into the community. Each exit portfolio was verified at the exit conference and included a state-issued identification card, copy of transition plans, calendar of dates, times and location of follow-up appointments, social security card, birth certificate, vocational certifications, educational records, résumé, and completed job applications. A review of three closed youth case management records confirmed each youth was provided copies of the required documentation. Each exit portfolio was discussed at the youth's exit conference and was provided to the youth upon their release from the program. The exit portfolios were also forwarded to the assigned juvenile probation officer (JPO) and the youth's home school district while documented in the youth's case record.

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

Three closed youth case management records were reviewed and indicated an exit conference was conducted after the juvenile probation officer (JPO) was notified, within fourteen-days prior to the release of each youth, and held separately from the transition conference. The treatment team leader, parent/guardian, education staff, JPO, youth, and other pertinent parties participated in the exit conference in person or by telephone. Those not able to attend in person, the treatment team leader noted telephone participants on the signature line of the exit form. A review of each closed record, the youth's date of admission and date of release coincided with the Department's Juvenile Justice Information System (JJIS). Reviewed documentation confirmed the treatment team leader invited the JPO, parent/guardian, education representative, and other pertinent parties connected to the youth's performance while in the program. Each reviewed exit conference was documented in the youth's records and included the date, summary of pending goals, and signatures of participants.

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 written policy and procedures addressing the purpose, requirements, and job description of the designated mental health clinician authority (DMHCA). The DMHCA serves as the clinical coordinator. The clinical director is dual licensed as a licensed mental health counselor and licensed marriage and family therapist under Chapter 491. The license for the mental health counselor and marriage and family therapist license expires on March 31, 2020. At a minimum, the DMHCA is on-site at least forty hours each week and is available twenty-four hours a day, seven-days a week. The clinical director is responsible for coordinating, verifying, and implementing mental health and substance abuse services. A copy of the mental health counselor license and marriage and family therapy license was obtained.

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

The program has a written policy and procedures addressing the purpose, requirements, and job description of the licensed and non-licensed mental health and substance abuse clinical staff. The program has a contracted agreement for professional services with a State of Florida board-certified psychiatrist who is scheduled to be on-site every other Friday for a minimum of four hours and is on-call twenty-four hours a day, seven days a week for consultation. The reviewed documentation confirmed the licensed staff works within the scope of license, experience, and training. The license for the psychiatrist is due to expire on January 31, 2020The program has an operating permit through the State of Florida, Department of Health for Group Care-Residential Treatment Facility. The operating permit expires on September 30, 2019.

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 clinical director serves as the clinical supervisor and assures the non-licensed clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. Non-licensed mental health and substance abuse clinical staff receive one hour of on-site face-to-face direct supervision by the licensed clinical supervisor primarily in a group format as permitted by law within their Florida licensure. The reviewed documentation confirmed direct supervision is recorded on a form containing all information as outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log. The program has three master's-level mental health and substance abuse clinicians who work under the direct supervision of the designated mental health clinician authority (DMHCA). Two non-licensed mental health clinical staff who conduct Assessments of Suicide Risk (ASR) have completed twenty hours of training which included five assessments of suicide risk documented on the Department's Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. One master's-level clinician is still in training and was not conducting ASRs at the time of the annual compliance review.

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

The program has developed a written procedure for the implementation of a standardized screening process at admission. The standardized procedure for the screening process includes review of the commitment packet information, reports and records, alerts, and administration of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) on the Department's Juvenile Justice Information System (JJIS) or clinical mental health screening by a qualified professional and referral of juvenile offenders identified by screenings as in need of further evaluation or immediate attention. The reviewed procedures address staff training in mental health and substance abuse issues and administration of the MAYSI-2. The interview with the program director (PD) confirmed this screening process utilized to identify youth at risk for mental health and substance abuse problems. The reviewed policy outlines the process for referral of youth identified as in need of further mental health and/or substance abuse evaluation to the designated mental health clinician authority (DMHCA) or licensed mental health professional and the referral to a hospital when immediate attention is needed. Seven youth mental health and substance abuse records were reviewed., All records indicated staff reviewed each youth's commitment packet information, reports, and records. All seven reviewed mental health and substance abuse records had MAYSI-2 screenings completed for each youth on the day of admission in a confidential manner. All seven reviewed MAYSI-2 screenings were completed in full in the Department's Juvenile Justice Information System (JJIS). Training was verified for all four staff who conducted MAYSI-2 screenings. Six reviewed MAYSI-2 screenings indicated each youth needed further assessment based on the MAYSI-2 Scoring Summary and referrals were made for each youth. Documentation further supported the program director (PD)

and/or designee was notified when a referral was made. Three MAYSI-2 screenings with scores in suicide ideation were referred for an Assessment of Suicide Risk (ASR). All ASRs were conducted within twenty-four hours. All three records reflected the staff making the referral documented a consultation with the DMHCA or the program's licensed mental health counselor (LMHC).

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 to refer youth who are identified by screening after admission shall be referred for further evaluation. Seven reviewed mental health records had referrals for all youth on the date of admission. All seven reviewed mental health records had new mental health comprehensive evaluations completed within thirty calendar days of admission and were signed by a licensed qualified professional within ten calendar days of the completed evaluation. All seven reviewed mental health evaluations included identifying information, reason for evaluation, relevant background information, behavioral observations, and mental status exam. The reviewed seven mental health evaluations discussed findings, interview and procedures administered, diagnostic impressions to include Diagnostic and Statistical Manual, Fifth Edition (DSM-5) diagnosis, and recommendations. A review of seven youth records reviewed found the substance abuse evaluations were signed by a licensed mental health professional licensed under F.S. 491 in all records. All seven substance abuse evaluations were completed within thirty-days of admissions and all seven youth had consent obtained for substance abuse services. All seven substance abuse evaluations included the reason for assessment, relevant background information, behavioral observations, and methods of assessment. All seven reviewed substance abuse evaluations reflected the patterns of alcohol and other drug abuse, the impact of alcohol and other drug abuse on major life areas, and risk factors of continued substance abuse. All seven reviewed substance abuse evaluations addressed the reason for referral and discussed clinical impression including DSM-5 diagnosis coupled with recommendations.

3.06 Mental Health and Substance Abuse Treatment	Satisfactory Compliance
Mental health and substance abuse treatment planning in Departmental facilities focuses on providing mental health and/or substance abuse interventions and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. *The treatment team is responsible for assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans.*	

The program has a written policy and procedures related to mental health and substance abuse treatment planning which focuses on providing mental health and/or substance abuse interventions and treatment. All seven reviewed youth mental health records indicated each youth were assigned to a multidisciplinary treatment team upon arrival to the program. All seven reviewed youth records reflected team documentation verified the youth's multidisciplinary treatment team is comprised of the youth, program administration, living unit, education, medical, mental health and substance abuse clinical staff, and the parent/guardian of the youth when possible. An observation of a multidisciplinary treatment team meeting confirmed there

were representatives of all departments in attendance. It was reported the parent/guardian was unable to participate by telephone due to an employment requirement. All seven records reviewed for mental health and substance abuse determined youth were in need of mental health and substance abuse services and received individual, family, and group counseling provided by a licensed qualified professional or a non-licensed substance abuse clinical staff under the direct supervision of a licensed qualified professional in accordance with the youth's individualized treatment plan. All seven reviewed youth mental health and substance abuse records had properly executed Authority to Evaluate and Treatment (AET) forms and signed Substance Abuse Consent and Release forms. All seven reviewed mental health records had mental health and substance abuse notes documented on a form containing all information the Department's Counseling/Therapy Progress Note. Reviewed documentation indicated mental health groups were limited to ten or less youth. Substance abuse groups were limited to fifteen or fewer youth and individual psychotherapy was one-to-one counseling between youth and mental health clinical professional. Seven reviewed youth treatment plans identified psychosocial skill training which were designed to address specific skill deficit or maladaptive behaviors and promote skill development and improved functioning of each youth. Staff and the designated mental health clinician authority (DMHCA) interviews confirmed youth receive mental health and substance abuse groups which are conducted by qualified clinical staff. Six of the seven interviewed youth reported they were receiving group and individual mental health services. One youth responded they were currently not involved in individual and/or groups counseling as the youth successfully completed the interventions. A review of the youth mental health record and an interview with clinical staff, indicated the youth was actively participating in individual therapy and groups.

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.*	

A review of seven youth mental health and substance abuse records determined each youth had an initial treatment plan developed on the date of admission which was documented on the form containing all information on the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Six of the seven reviewed initial treatment plans had initial mental health and substance abuse treatment plans created within seven days of the onset of treatment. One reviewed youth mental health and substance abuse treatment plan was not created within seven days of the youth being prescribed psychotropic medication from the initial psychiatric diagnostic interview. This was explained and confirmed the youth was in obvious distress and was admitted to a Backer Act facility. Seven reviewed initial treatment plans were signed by the mental health and substance abuse clinical staff who completed the form and the treatment team members who participated in the development of the plan which included the youth. All seven initial treatment plans included the signature of the licensed clinical supervisor within ten days of completion. A review of three applicable youth records where the youth was admitted on psychotropic medications found two documented psychotropic medication and frequency on the

initial treatment plan. All seven individualized treatment plans were developed within thirty days of admission containing all information as outlined on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. All seven individualized treatment plans were signed by the mental health and substance abuse clinical staff who completed the plan and each treatment team member who participated in the development of the plan. A review of seven individualized treatment plans were signed by the licensed supervisor within ten days of completion. One individualized treatment plan of a youth on psychotropic medication identified the name of medication and did not include the frequency of monitoring by the psychiatrist. A review of six of the seven individualized treatment plans documented the prescribed services which included the duration and frequency of individual, family, group, and psychiatric services. Six of the seven reviewed mental health and substance abuse group notes did not include start and/or end times on every progress note to determine group services were delivered in compliance with the individualized treatment plan. All seven reviewed individualized treatment plans were completed on a form containing all information as outlined on the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form. Seven reviewed treatment plans confirmed the treatment plan reviews occurred within thirty days of the development of the treatment plan. Seven reviewed treatment plans indicated each youth's review occurred within thirty days of the previous treatment plan review. Three mental health and substance abuse discharge plans were reviewed. All three reviewed Mental Health/Substance Abuse Discharge Summaries were not completed on the Department's Mental Health/Substance Abuse Treatment Discharge Summary 2014 form; although, they were completed on the 2006 Mental Health/Substance Abuse Treatment Discharge Summary form and contained all required information. All three Mental Health and Substance Abuse Discharge Summaries considered the services needed for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by the youth during treatment. It was confirmed all discharge plans are discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. A copy of the discharge summary is provided to the youth, JPO, and parent/guardian as allowed.

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

The program has a written policy and procedures to deliver specified treatment services in the discipline of substance abuse overlay services (SAOS) for youth in program. The program is contracted to provide comprehensive services of major disorders to youth. A review of seven youth mental health and substance abuse records and an interview with the designated mental health clinician authority (DMHCA) confirmed, the ongoing provision of the comprehensive clinical services for major disorders or substance abuse diagnosis to the youth in the program. An interview with the program director (PD) indicated youth receive substance abuse treatment services seven day a week. The curricula used is Seeking Safety, Living in Balance, Wisdom to Know the Difference, Stop the Chaos, and Mindfulness of Addiction. Services provided includes mental health and substance abuse evaluations, treatment planning, daily group therapy session, individual sessions which are conducted twice a month, monthly family therapy, substance abuse therapeutic activities, mental health crisis intervention, and daily on-site psychiatric services, twenty-four hours a day seven days a week crisis intervention therapy services, and suicide prevention.

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 provides psychiatric services through an independently contracted and licensed psychiatrist. The psychiatrist is scheduled to be on-site every other Friday for four hours and is available by phone twenty-four hours a day, seven days a week for consultation. An interview with the psychiatrist and program staff confirmed this schedule is adhered to. All seven reviewed youth mental health and substance abuse records confirmed the initial psychiatric interview included the history of the youth, a mental status examination, a documented Diagnostic and Statistical Manual, Fifth Edition (DSM-5) diagnosis, and treatment recommendations. Reviewed documentation confirmed all seven youth were referred to the psychiatrist and received an initial diagnostic interview which was documented on the three pages of the Clinical Psychotropic Progress Note (CPPN) form within fourteen days of admission. The initial diagnostic interview identified three youth arriving to the program on psychotropic medication. One youth was prescribed psychotropic medication following their initial psychiatric interview and one youth was prescribed psychotropic medication after their initial psychiatric interview. Reviewed documentation confirmed three youth prescribed psychotropic medication at the time of the initial psychiatric interview had an explanation of the need for psychotropic medication related to the youth's diagnosis, potential side effects, the risks and benefits of taking the medication, and the frequency of medication monitoring and management. All four youth records confirmed youth on psychotropic medication had documentation to support each youth being seen for medication review by the psychiatrist every thirty days and was completed on all three pages of Department's CPPN form. Documentation confirmed the psychiatrist as a member of the treatment team for the four youth on psychotropic medication. Review of documentation confirmed the psychiatrist visits the program as required by contract as validated from a review of sign-in sheets for the past six months. Reviewed documentation confirms the psychiatrist has the ultimate responsibility for the prescription and monitoring of psychotropic medication in the program and actively participates in, manages, and supervises medication services in 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 has a written plan detailing suicide prevention procedures to include identification and assessment of youth at risk of suicide. The reviewed suicide prevention plan identified suicide precautions, level of supervision, referral, communication, notification, documentation, and immediate staff response. The suicide prevention plan outlines staff training and the review process. The plan is reviewed annually and was signed and dated by the program director (PD) and the licensed mental health professional on August 2, 2019. The program has not experienced a youth attempting suicide since the last annual compliance review. A review of seven staff in-service and seven staff pre-service training records confirmed all staff participated in the six hours of annual training on suicide implementation and precautions. In addition, a

review of the program's emergency drill binder dating back nine months found mental health and suicide drills were conducted on all three shifts on December 18, 2018, March 14, 2019, and June 25, 2019. The drill results were captured on the emergency form including staff who participated, what role staff played and any recommendations for improvement.

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 utilizes suicide precautions for supervising, observing, monitoring, and housing youth identified through screenings, available information, and staff observations as having suicide risk factors. Three suicide episodes were reviewed for youth who were placed on precautionary observation during the annual compliance review period. All three reviewed records indicated each youth was referred for an Assessment of Suicide Risk (ASR). All three reviewed records identified how and when the youth was determined to be at risk for suicide. Two of three reviewed records identified the youth being placed on precautionary observation (PO) prior to the ASR as one mental health and substance abuse record identified the youth being placed on PO with constant supervision following a score in suicide ideation from the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) assessment at intake. One record identified the youth returned to the program from transport on PO with constant supervision. The form was noted to have been completed in real time by a licensed staff. The two reviewed records of the youth who were placed on suicide precautions were not determined to be a potential risk for suicide following the ASR and were transitioned directly to standard precautions. One reviewed record indicated PO was authorized and the youth was placed on PO with one-to-one supervision immediately as the youth was deemed to be in crisis following statements made to program staff. A review of records identified the youth remained on PO until a follow-up ASR was completed. All three records confirmed the ASR was completed on the Department's Assessment of Suicide Risk form. The follow-up ASR for the one youth who remained on PO was completed on the Department's Follow-Up Assessment of Suicide Risk form, which included all required elements. The reviewed follow-up ASR transitioned the youth to close supervision after the licensed mental health professional deemed the youth no longer at risk prior to returning to standard supervision. Reviewed records confirmed a conference was held by the program director (PD) and licensed mental health professional to reduce level of supervision and the discontinuation of close supervision is documented in accordance with the program's suicide prevention plan. The program has procedures in place to verbally notify the juvenile probation officer (JPO) and the parent/guardian of the youth's potential suicide risk and review of the ASR documented notification was made to the JPO and parent/guardian. All three mental health and substance abuse records confirmed the mental health staff provided supportive services for each youth. All three reviewed records confirmed the ASR was completed by a licensed mental health professional or clinical staff under the direct supervision of a licensed mental health professional. The three pertinent reviewed records confirmed an alert for suicide was entered into the Department's Juvenile Justice Information System (JJIS).

The alert was subsequently removed immediately after the youth was removed from PO by a mental health professional. Reviewed documentation confirmed the three youth were allowed to participate in select activities with other youth in designated safe areas and PO did not limit the youth's activity to an individual room or restrict the youth to their sleeping room. Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk forms were reviewed and confirmed the two non-licensed clinicians completing ASRs completed twenty hours of required training by licensed mental health professional which included five co-assessments. One non-licensed clinician is still receiving training. The ASR and follow-up ASR completed by non-licensed clinicians were signed by the licensed mental health professional or consultation via telephone if not on-site and signed by the licensed mental health professional at the time the assessments were completed, or the next arrival on-site. All three reviewed ASRs documented the actual date and time the clinician conferred with the licensed mental health professional and PD. The program's logbooks were reviewed and there was documentation of the instructions related to the suicide risk assessment findings and communication to staff for oncoming shifts. The program has two suicide response kits which include the knife-for-life, wire cutters, and needle nose pliers. The program has an established multidisciplinary review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide which included the circumstance surrounding the event, facility procedures related to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations for changes in policy, training, physical plant, medical or mental health services, and operational procedures. Secure observation was not rated as the program does not utilize this type of restriction. Seven staff were interviewed and all provided consistent responses on where to locate the suicide response kit in master control and the contents thereof. Five of the seven interviewed staff further responded suicide kits are stored in the program's transport vehicle. Staff were also consistent on their responses for the process on the steps to proceed should a youth express suicidal ideation. All staff responded they would notify the mental health authority or designee, search the youth room for sharp objects, maintain sight and sound supervision, and document the supervision.

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.	

Three suicide precaution observation (PO) logs were reviewed for three youth placed on PO during this annual compliance review period. All three PO reports were completed on the Suicide Precaution Observation Log and maintained for the duration each youth remained on suicide precaution. All three reviewed PO logs documented the appropriate level of supervision and observations of the youth's behaviors were documented within thirty-minute intervals. The review of the three PO reports documented each log was reviewed and signed by each shift supervisor and the mental health clinical staff. All three reviewed PO logs documented safe housing requirements to determine if safe housing requirements were met, supervision, supervisory reviews, and response to warning signs. The three youth who were placed on PO were interviewed and confirmed staff were with each youth while on suicide precaution and were not left alone for any period of time.

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.	

A review of seven staff in-service training records indicated each staff member received the required six hours of annual training on suicide prevention and implementation of suicide prevention which included mock suicide drills held quarterly on every shift for staff with direct contact with youth. The review of six mock suicide drills provided training on each shift on lifesaving measures which included cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and suicide kit location and contents. Reviewed training documentation confirmed fifty percent of staff with direct contact with youth participated in at least one mock drill which included CPR and participated in quarterly drills with a minimum of one quarterly drill semi-annually. A review of documentation confirmed staff members not present during a quarterly drill had the opportunity to participate in each drill scenario and procedure during the following monthly all staff meeting, in effort to receive necessary training of how to respond to an incident should a suicide attempt or incident of serious self-inflicted injury occur in the program.. In addition, a review of seven pre-service staff training records reflected all had received a minimum of six hours of suicide prevention and observation within their training academy curriculum.

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

The program has a written crisis intervention plan. The reviewed crisis intervention plan includes notification and alert system, communication, and documentation. The crisis intervention plan identified the means of referral including youth self-referral and outlined supervision of one-to-one, constant, and standard supervision. The plan was reviewed, signed, and dated by the program director (PD) and the licensed mental health professional on August 2, 2019.

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

The program has a written policy and procedures to assess youth in crisis. A review of seven youth mental health and substance abuse records found none were applicable for crisis

assessments. A review of the Department's Juvenile Justice Information System (JJIS) further found no alerts for crisis assessment. The program did not have applicable youth for crisis assessment since the last annual compliance review. The program has internal procedures addressing crisis assessments coupled with trained mental health staff to recognize and address youth exhibiting crisis behaviors in need of immediate assessment and intervention. The program utilizes the Department's Crisis Assessment form pursuant to Rule 63N-1 to conduct crisis assessments. The assessments are inclusive of the reason for the assessments, mental status examination and interview, determination of danger to self or others, initial clinician impressions, supervision recommendations, treatment recommendations, follow-up or further evaluation, and notification to parent/guardian of follow-up treatment. The program's protocol for crisis assessment is conducted by a license mental health professional or a non-license mental health clinical staff person working under the supervision of the licensed designated mental health clinician authority (DMHCA). The program's DMHCA and the program director (PD) are notified of the crisis assessment for concurrence or non-concurrence of the mental health crisis alert placement and level of supervision to be implemented when necessary.

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

The program has a written emergency mental health and substance abuse emergency response plan signed by the program's designated mental health clinician authority (DMHCA) on July 25, 2019. The reviewed plan included immediate staff response, notifications, communication, and supervision. The program's emergency response plan detailed the authorization to transportation for emergency mental health and substance abuse services. The plan identified Memorial Regional Hospital as the designated hospital to transport the youth for emergency mental health evaluation and treatment under Chapter 394 F.S. (Baker Act). The plan identified Memorial Regional Hospital as the designated hospital to transport the youth for emergency substance abuse assessment and treatment under Chapter 397 (Marchman Act). The reviewed emergency mental health and substance abuse plan included documentation, review, and training. A review of the program's mock emergency drill binder reflected the program was conducting drills for mental health crisis and suicide attempts on all shifts on a quarterly basis dating back to the last annual compliance review.

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

The program has a policy and procedures in place for individuals who are believed to be an imminent danger to themselves or because of mental illness or substance abuse impairment requiring emergency services. During the annual compliance review period, one youth mental health and substance abuse record was applicable for Baker Act. The reviewed youth record confirmed the youth was determined to be in need of emergency care. The staff response was immediately made by the clinical director who initiated the Baker Act process. Reviewed documentation indicated the youth in need of emergency intervention was already placed on precautionary observation (PO) with one-to-one supervision. Documentation validated the

information and an interview with the program director (PD) confirmed they had authorized program staff to transport the youth to receive emergency mental health services. Reviewed documentation confirmed the youth returning to the program following their admission under the Florida Baker Act was placed on constant supervision upon return to the program. The review of an Assessment of Suicide Risk (ASR) confirmed a Mental Status Exam (MSE) was conducted and the ASR was completed by a licensed mental health professional. The review of documentation confirmed the youth remained on PO with constant supervision until the youth was able to transition to a lower level of supervision after the appropriate assessment was conducted and mental health staff along with the licensed mental health professional and the PD conferred, agreeing to the change in supervision.

Standard 4: Health Services

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

The program maintains an independent contractor agreement for professional services with a State of Florida licensed medical doctor (MD) effective August 23, 2016. The MD holds an active, unrestricted license under chapter 458, Florida State Statute and is responsible for the overall clinical healthcare services provided to youth in the program. The MD's education and specialty training are in pediatric emergency care medicine. The physician serves as the program's designated health authority (DHA) and is scheduled to be on-site a minimum of two hours each week. A review of the sign-in log validated the DHA was on-site weekly. Sign-in and sign-out times were documented for each week. According to the agreement for professional services, the DHA is on-call twenty-four hours a day, seven days a week for consultation by mobile telephone, and is responsible for communication with the nursing staff regarding youth medical needs. Reviewed documentation confirmed coverage is provided by one of the two program's part-time advance practice registered nurse (APRNs) when the DHA is on scheduled leave or unavailable. An interview with the health services administrator (HSA) indicated the program does not have a back-up physician to provide services when the DHA is on leave. The practice is for the DHA to clinically review the administrative work of the APRNs upon return. According to Department's Rule 63M-2.0031, the DHA must be on-site at least once a week, with no more than nine days passing between visits. Additionally, the program's contract states, "there shall be uninterrupted and equivalently qualified coverage of physician services. In the event of the physician's absence, the Provider will ensure physician coverage." Both APRNs have education background in internal medicine and both have collaborative practice protocols in place. Reviewed documentation supported the DHA maintains a current certificate of liability insurance. In addition, the program maintains an agreement for professional services with a State of Florida licensed psychiatrist to provide services to youth on prescribed psychotropic medications. The program also maintains an agreement for professional services with a dentist to provide comprehensive dental services to youth and the program maintains an agreement for professional services with a State of Florida licensed optometrist to provide a comprehensive array of eye care services to the youth. The program maintains a nursing protocol manual developed and approved by the DHA. A review of the licenses for all medical professionals providing care to youth validated each held a clear and active license in the State of Florida. The DHA license expires on January 31, 2020 and the APRNs licenses expire on April 30, 2021, and April 30, 2020, respectively. The HSA registered nurse (RN) license and the other program's RN license both expire on July 31, 2020.

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 (FOP) for all health-related treatment. The program's policies and protocols outline the program's healthcare services. The program's designated health authority (DHA) and program director (PD) conducts an annual review of all health-related policies, procedures, and protocols. Approval of treatment protocols or standing

procedures are to be written and authorized by the DHA and are not to be designated to any other person. The program maintains a training requirement whereby all healthcare and program staff will have access to the FOP's regarding healthcare. Nursing staff sign and date a cover page on which all FOPs, treatment protocols, and other procedures follow in a healthcare FOP notebook. New policies or changes in policies made during the year are reviewed, signed, and dated by each member of the nursing team. Reviewed documented practice identified the DHA and both registered nurses (RN's) sign the FOP acknowledgement form. There were no general corporate policies, procedures, or protocols for review.

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 each youth maintains a signed and dated Authority for Evaluation and Treatment (AET) form in the healthcare record. The AET form is signed by the parent/guardian and serves as informed consent for non-invasive medical procedures or for minor ailments requiring over-the-counter (OTC) medications which can be treated by healthcare staff. A signed AET is required prior to the program providing medical services. A review of seven youth individual healthcare records (IHCRs) found six contained an AET and one contained a court order. The six reviewed AETs were not an original; however, the word "Copy" was clearly stamped. One youth had a court order since they were in the custody of the Department of Children and Families (DCF). Each reviewed AET and/or release of information form was filed in each youth's IHCR in the appropriate section. There were no youth with a break in service since their AET was signed. There were no AETs reviewed where a parent/guardian refused to sign the AET. Six of the seven interviewed staff members indicated they received AET training.

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 condition and to obtain consent when new medications and treatments are prescribed. A review of seven youth individual healthcare records (IHCRs) supported four were applicable where the parent/guardian were notified of over-the-counter (OTC) medications beyond those covered by the AET, when a youth was prescribed a new medication, when a medication prescribed prior to the youth's admission was discontinued, and when youth was taken off-site for medical treatment. There were no applicable reviewed IHCRs of youth requiring off-site emergency care, hospitalizations, and/or surgeries. One youth was in the custody of the Department of Children and Families (DCF) and the circuit court provided the appropriate court order for the youth to receive treatment while in the program. The program also mailed written notifications to each parent/guardian when required. In one case of initiation of psychotropic medications the parent/guardian consent was documented through the Department's Clinical Psychotropic Progress Note (CPPN). In all the seven IHCRs reviewed, the youth's vaccinations were verified by the program's medical staff within thirty-days of the youth's admission.

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 to the program. The procedures ensure a rescreening shall be completed when the physical custody of the youth changes and youth are subsequently returned or readmitted. The parent/guardian is notified to obtain consent of new medication, discontinuances, or adjustments. A review of seven youth individual healthcare records (IHCRs) found each youth has a Facility Entry Physical Health Screening Form (FEPHS) completed by a registered nurse (RN) on the date of the youth admission to the program. There were no applicable youth where there has been a change in physical custody since the youth's arrival requiring a FEPHS re-screening. An interview with the program's health services administrator indicated only licensed healthcare staff complete the FEPHS form.

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. Seven youth individual healthcare records (IHCRs) were reviewed and each validated the youth completed a comprehensive general orientation to the Department's healthcare system. A review of each orientation included all the required topics and was signed and dated by the youth and the registered nurse (RN) who provides the orientation. The review of each youth's Health Education form confirmed youth received orientation in all the required topics. Observation of the program's clinic confirmed the program maintained a list of healthcare contacts, the emergency names and telephone numbers. Each youth's orientation packet and list of healthcare contacts were reviewed during orientation to ensure accuracy.

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 maintains a written policy and procedures ensuring all youth are screened for health-related conditions at the time of admission to help identify any health concerns. The program practice is for the designated health authority (DHA) or designee to be notified by telephone of all admissions and when a youth admitted require emergency care or routine notification in accordance with Department requirements, such decisions are made for appropriate referrals. Youth admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone. Nursing staff document the notification on the DHA and Psychiatrist Notification of Admission form. The nurse signs the form and the DHA signs the form at the next on-site visit. In addition, the nurse documents the notification in the chronological nursing intake progress notes in the youth's individual healthcare record (IHCR). A review of seven IHCRs validated this practice. In three of the seven IHCRs reviewed for youth with known or suspected chronic conditions, the applicable referral to the DHA was completed at admission.

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 or at the same time as the Comprehensive Physical Assessment (CPA). The written policy and procedures ensure effective planning for the well care, routine, acute, and chronic healthcare needs of the youth. All youth admitted receive and/or have a current HRH form completed. The nursing staff completes the Department's HRH form prior to the CPA. A review of seven youth individual healthcare records (IHCRs) found a new HRH was completed by a registered nurse (RN) for each youth within seven days of the youth's admission. The RN and the designated health authority (DHA) documented their review of the HRH by signing the form. In addition, the DHA documented a review on the completed CPA. Each HRH reviewed was completed before or at the same time as the CPA. An interview with the RN confirmed the HRH is always completed by the medical department the same day of youth's admission to the program.

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 policy and procedures ensure effective planning for the well care, routine, acute, and chronic healthcare needs of the youth. All youth admitted receive and/or have a current Comprehensive Physical Assessment (CPA). A review of seven youth individual healthcare records (IHCRs) validated the program utilizes the Department's standardized CPA form. All CPAs were completed by the designated health authority (DHA). All sections of the CPA were completed in full utilizing "O" or a "X". One reviewed CPA indicated the youth refused a portion of the examination and the youth documented their signature of refusal on the CPA. A review of the documented practice validated the Department's Problem List was updated for each youth throughout their stay, when applicable. All reviewed CPAs were completed in full. The program has a current policy and procedures regarding tuberculosis (TB) screening, whereby the program follows the Centers for Disease Control and Prevention recommendations and the Occupational Safety and Health Standards (OSHA). A review of seven youth IHCRs validated each youth had at least one verified tuberculin skin test (TST) documented within the last year to determine exposure to TB. 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 TB screening. All Tier I TB screenings were conducted on the day of each youth's admission. A review of the documented practice found the results of the TST were documented on the youth's CPA and on the Department's Infectious and Communicable Disease (ICD) form. The program also maintains a record of all TST administered which are documented on the Department's Tuberculosis Testing log. When applicable, all positive TST results are reviewed by the DHA or designee.

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). A youth who reports signs/symptoms consistent with an STI, or reports they are sexually active shall be referred to the designated health authority (DHA) for an evaluation and screening with testing, if applicable. The DHA shall then decide, based on the evaluation which test to perform to prevent the advancement of the infection and to decrease the risk of future transmission. A review of seven youth individual healthcare records (IHCRs) revealed each youth was referred to the DHA. Testing was ordered and was performed for four youth. Test results were filed in the lab section of the youth's IHCR and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. 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. In an interview with the registered nurse (RN), it was indicated each youth is screened for STIs upon admission to the program and when requested by youth. The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered testing, counseling, education, prevention counseling, and a referral for medical treatment, as indicated. Testing is also offered to all youth after completion of an educational course in sexually-transmitted diseases and HIV. A review of seven youth IHCRs validated each youth was offered the opportunity to receive counseling and testing for HIV. Seven youth were interviewed and indicated they can request an HIV test. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. The program's corporate registered nurse (RN) is authorized to provide pre-counseling, testing, and post-counseling. A copy of the RN HIV/AIDS 501 certificate was reviewed with an expiration date of December 31, 2020. A review of seven youth IHCRs validated four youth who consented was offered and received pre-counseling, testing, and post-counseling. The youth's Health Education Record is updated in the IHCR. The results are placed in a sealed envelope marked 'Confidential' with the youth's name documented on the outside of the envelope. All seven interviewed youth confirmed they can request an HIV test.

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

The program maintains a written policy and procedures ensuring all youth shall be able to make a sick call request and have their complaints treated appropriately through the sick call system. Review documentation and an interview with the registered nurse (RN) indicated the nurse is notified through printed Sick Call Request form. Non-emergency healthcare needs will be addressed through the process of a nurses' sick call. Observations made during the program's tour, found the Sick Call Request forms were available to all youth in the program. The youth have unimpeded access to the designated health authority (DHA), if they feel proper treatment has not been provided because of sick call. This also includes a referral to a specialist when indicated. The program maintains an agreement for professional services with a State of Florida

licensed dentist to provide professional dental services to youth and an agreement for professional services with a licensed optometrist, who has a clear and active license in the State of Florida. The program offers youth the opportunity to sick call Monday through Friday at 10:00 a.m. and 2:00 p.m., and Saturday and Sunday at 8:00 a.m. and 5:00 p.m. which are conducted by the RN. Seven interviewed staff indicated the nurse conducts sick call in the program. A review of seven youth individual healthcare records (IHCRs) validated each youth completed a sick call request form at least one time during their stay. The RNs 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. The dental sick call is incorporated into the healthcare sick call process. When a licensed healthcare staff is not on-site, all sick call request forms shall be turned into the shift supervisor for review. The shift supervisor/lead staff is required to review the sick call complaint promptly but no longer than two hours after the request was submitted. The shift supervisor will determine if the sick call requires immediate attention. The DHA is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. The nursing staff leaves an over-the-counter (OTC) medication box for the shift supervisor/lead staff when nursing staff are not on-site in case an OTC medication is required. The DHA developed and approved protocols for non-licensed staff to utilize when nursing staff are not on-site. The program maintained a Sick Call/Referral Log documenting the youth's name, date, time, youth's signature, and nature of the sick call on the log forms. Observation of a sick call confirmed this practice. All sick calls provided was also documented on the Sick Call Index. All seven interviewed youth confirmed they make sick call requests and they can see a nurse immediately. An interview with the RN indicated the program has two sick call boxes available on both sites of the program. The boxes are checked prior to conducting sick call. All seven interviewed staff indicated only the nurse conducts 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 to ensure the provision of episodic/first aid care are available to the youth at the program. The program also has 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. Reviewed documentation found the program has emergency medical and dental care including emergency medical services (EMS) practice available twenty-four hours a day. A licensed dentist and the designated health authority (DHA) or psychiatrist will accomplish this through a screening examination or the nursing staff may examine the youth, or by self-reporting from the youth. A review of seven youth individual healthcare records (IHCRs) found four youth requiring episodic and/or first aid care. 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 (RN) initials, and whether the youth was referred to the DHA. All seven interviewed youth indicated they can see a dentist if they have tooth pain. The program maintains one automated external defibrillators (AED), seven first aid kits, and two suicide response kits each containing a knife-for-life, wire cutters, and needle nose pliers. During an interview with one RN, it was found the RNs monitors the first aid kits weekly and replenished them, as needed. In addition, the program maintained two epinephrine auto-

injectors located in the medical clinic. There were no youth prescribed an epinephrine auto-injector at the time of the annual compliance review. The first aid kits and AED are checked weekly by nursing staff and documented on the program-specific First Aid Kit/Bloodborne Pathogen Kit/ AED Review form. There was no documented practice of non-healthcare staff conducting episodic and/or first aid care since the last annual compliance review. This was validated through nursing interviews. All program staff, contracted employees, teachers, and volunteers have the right to contact 9-1-1 in any life-threatening situation involving a youth in the program. An interview with the RN indicated the program's AED is in the program's master control area and available to all the program staff. During an inspection of the AED device, it was found the batteries expire on October 13, 2022 and the pads expire on May 28, 2021. The list of emergency numbers is posted in the medical department and in master control and not accessible to youth. 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. Observation confirmed the program has a list of emergency telephone numbers posted in the clinic and master control. 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 training. Nursing staff maintained current certifications in CPR and AED. The program conducts mock medical drills at least bimonthly on each shift. Reviewed drills supported an annual calendar is maintained identifying the drill to be conducted each month to ensure each shift and staff are participating in a variety of drills. A review of the documented practice found the mock emergency drills included CPR and AED demonstration. Observations during the tour of the program found postings throughout the facility informing staff of their right and responsibility to call 9-1-1. Reviewed documentation did not clearly identify the emergency drills were conducted both announced and unannounced for each shift. Reviewed documentation did not support all staff with direct contact on a day-to-day basis participated in at least one emergency man-down drill annually. Reviewed monthly medical drill calendar will ensure each staff is provided the opportunity to participate in the medical drills as required. The program director (PD) provided all-staff meeting agendas and minutes to validate the RN is reviewing all medical alerts and medical drill information. The RN discusses the drill event and provides a critique. All seven interviewed staff members indicated they are personally allowed to call 9-1-1 if a youth has a medical emergency. All seven staff also indicated the nurse provides medication 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 related to off-site care and referrals to ensure timely referrals and coordination of medical services to off-site healthcare providers. A review of seven youth individual healthcare records (IHCRs) indicated one of the seven was applicable for off-site care referrals. Two additional closed records applicable for this process were also reviewed to verify practice. In each of the three applicable reviewed records, the parental/guardian notifications were completed and the Department's Summary of Off-Site Care form was utilized and placed in each applicable IHCR, as required. Each reviewed IHCR confirmed the designated health authority (DHA) or designee reviewed and signed all off-site care findings, instructions, and information. One of the three youth required follow-up testing

and the case record showed evidence referrals were tracked and youth received appropriate and timely follow-up care, as needed.

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

The program maintains a written policy and procedures ensuring a uniform process exists to inform staff of the important information about a youth's medical and mental health status on an as needed basis. To ensure a proactive health program exists which provides care for chronically ill and developmentally disabled youth who require close medical supervision and multidisciplinary care is shared appropriately. Youth identified with a chronic condition receive regularly scheduled and as-needed follow-up care. A review of seven youth individual healthcare records (IHCRs) indicated three youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. All three youth were classified with a medical grade of two through five. The program conducts the Center for Disease Control and Prevention (CDC) Body Mass Index Percentile Calculator for Child and Teens for each youth during the admission assessment process. The program maintains a youth roster of youth requiring periodic evaluations identifying the youth by name and chronic condition. Reviewed records supported each youth received periodic evaluations as required. During an interview with the designated health authority (DHA), it was indicated the DHA evaluates the youth at a minimum of every ninety days. There was no indication of lapses in care or missed periodic evaluations. Reviewed documentation supported each youth receives a new Comprehensive Physical Assessment (CPA) within seven days of their admission. The DHA diagnosis the chronic condition with a prescribed medication treatment plan. Approximately every ninety days, the DHA conducts a periodic examination of the youth and if applicable, continues the youth on the specialized treatment plan and/or modifies the plan as necessary. The Department's Problem List was found to be updated when appropriate. An interview with the program director (PD) indicated meetings are conducted daily where medical issues are discussed and reviewed with the participation of the nurses.

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 the accurate and safe administration of medication is in place. Nursing 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 medications or order/prescriptions for medications, the healthcare staff will conduct a preliminary assessment and interview to determine the medication is verified as indicated. Nursing staff completes the Facility Entry Physical Health Screening (FEPHS) form to determine medical needs. The signed Authority for Evaluation and Treatment (AET) serves to continue the present medications and administer the medications as ordered. Nursing staff completes the Department's Prescription Medication Verification Checklist and place the completed form in the youth's individual healthcare record (IHCR). A review of seven youth IHCR's indicated four youth were admitted into the program on prescribed medication. Reviewed nursing admission notes documented the youth's current medication and the designated health authority (DHA) and Psychiatrist Notification of Admission was documented

during the youth's admission. Reviewed Medication Administration Records (MARs) validated this practice. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. The program also ensures the accurate and safe administration of medication. Each youth receiving medication shall have a current, valid order and are given pursuant to a current prescription or practitioner's order. A review of seven youth IHCR's validated four youth were applicable for medication management and each record documented a current and valid prescription order. Observation of a medication pass confirmed this practice. Each reviewed youth IHCR indicated the prescribed medication was continued, discontinued, changed or a new medication was ordered. Each time the DHA's order sheet clearly documented the medication and dosage. In addition, the program ensures 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, and locked in a medication cabinet. Narcotics and other controlled medications were observed securely stored in the medication cart. The program practice is to store the mediations in a locked box located in the locked medication cart. The program has a list of six program supervisors authorized to assist in the delivery of medication including controlled substances. The program had one youth prescription secured in the locked box. Oral medications were not stored with injectable or topical medications. The program maintains a refrigerator for medications requiring refrigeration. There were no medications in the refrigerator at the time of the review; however, the registered nurses (RNs) maintained a refrigerator log and documented daily the temperature, as required. The program securely stored sharps separate from medications. There were no syringes in the program at the time of the annual compliance review. The program maintains a written process for the disposal and destruction of expired and/or discontinued medications. All controlled medications are disposed of by the consultant pharmacist and witnessed by the RN. All the other medications are returned to the pharmacist for destruction. An interview with the RN found the program utilizes a pre-printed Guardian Pharmacy MAR.

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 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 for OTC medications are to be inventoried using a perpetual inventory verified weekly to indicate the amount on hand, amount used, amount added, and amount remaining. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses (RN's) and documented on the youth's individualized Controlled Medication Inventory Record. Controlled substances were observed to be maintained behind two locks with two separate key access. Sharps are counted through a perpetual inventory and are verified weekly. A third shift to first shift count of controlled medications is required prior to medical staff beginning medication pass. Strict control and accountability of the running balance for each controlled substance is maintained. The program contracts with Guardian Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires on September 30, 2021. Reviewed documentation and an interview

with the pharmacist supported the consultant pharmacist conducted monthly on-site inspections, maintained a consultant pharmacist inspection log, and a consultant pharmacist monthly inspection report. Reviewed documentation supported the consultant pharmacist conducts a quarterly interdisciplinary risk reduction quality improvement process with the program director (PD), health services administrator, designated mental health clinician authority (DMHCA), and consultant pharmacist. Agenda and minutes are maintained highlighting administration, medication storage, pharmacy services, consultant pharmacists report, controlled substances, stock medication, expiration dates of medications, and continuous quality improvement event summary. The program maintains written procedures for the disposal of narcotics and other controlled substances. Program practice is for the consultant pharmacist and the RN to dispose of the medication by utilizing the RX Drug Buster. All disposed medications are documented on the Consultant Pharmacist Monthly Inspection form and copies are maintained in the medical clinic. Observations conducted during the annual compliance review week supported three youth prescribed medications inventories were accurate. The number of pills, tablets, or dosages remaining after each administered dosage were documented on the youth's Individualized Controlled Medication Inventory Record received with the medicine from the pharmacy or the Department form. Observation of a count completed by the RN confirmed the count matched ending inventory numbers. Two youth medications and three OTC medications were inventory with the assistance of the RN. The inventories were accurate. Three sharps were reviewed and inventories were found to be accurate. The program had one youth prescribed a controlled medication with no discrepancies found with the inventory count. The inventory was documented on the Department's Controlled Medication Inventory Record. A review of the program's counts from the past six months validated no discrepancies were identified with the counts. The program maintains a written policy and procedures ensuring accurate and safe administration of medications shall be provided pursuant to a physician order written in the youth's individual healthcare record (IHCR). Medications should be administered within one hour of the scheduled times unless specified by the designated health authority (DHA), psychiatrist, or as required by medication instructions. The RN's administering the medication will document their initials on the Medication Administration Record (MAR). Seven interviewed staff indicated the nurse provides the youth their medication and three also indicated the supervisor provides youth medication in the absence of the RN. Five of seven interviewed youth indicated they do not take medications. One youth indicated the nurse provides the mediation and one youth indicated other staff provides medication. A review of seven youth IHCRs found the program utilizes the Department's 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. There were four youth taking prescribed medications upon admission and the initial MAR matched the medication listed. The four reviewed applicable youth IHCRs supported the MAR documented the youth received the medications as ordered. The MAR clearly indicated the medication start and stop dates. Licensed staff and non-licensed staff initialed the MAR for each administered medication entry. There were no indications of lapses and/or errors in the medication administration. A review of the Department's Central Communications Center (CCC) database validated there were no incidents of missed medications since the last annual compliance review. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. Refusals were clearly documented on the MAR and nursing staff completes the Department's Refusal of Treatment form when a youth refuses a medication dosage. Prescribed medication is administered only by the order of the DHA or psychiatrist. A review of seven youth IHCRs validated four youth were prescribed medications. No youth required parenteral medication at the time of the annual compliance review; however, procedures are in place for only the licensed RN to administer the medication. Reviewed MAR for each youth as well as the prescription, validated the youth

received the medication as ordered and at the scheduled time frames. Observations of medication administration by a licensed RN indicated the medication was administered in accordance with the six rights of medication administration by verification of the right youth, right medication, right dose, right route, right time, and right documentation. Observation of the clinic revealed the work space was clean, well-organized, and the RN had control of the medication containers and cart. Observation of medication pass found the RN blocked the door to the clinic with the medication cart and the youth approached one at a time and identified themselves and the medication prescribed, the purpose of the medication, side effects, and whether the youth is experiencing side effects at the time of medication administration. One youth care worker stood behind the youth when the medication was administered. The RN then checked the youth's mouth and had the youth cough to ensure the medication was swallowed The youth care worker also checked the youth and had the youth cough to ensure the medication was swallowed. The RN did not pre-pour the medication from the blister pack after administration. The observed process was structured and interactive. The program maintains a written policy and procedures for youth self-administration of oral medications, topical, or inhaled prescribed medications assisted by non-licensed trained staff. The program has a list of six supervisors authorized to assist in the delivery of medication. Non-licensed staff shall provide self-administration medication only when there is not a licensed healthcare staff on-site and only if they have been trained to assist in the delivery of oral medications. Reviewed documentation supported the RN has trained the six non-healthcare supervisory staff to assist in the delivery of oral medications to youth. The DHA has developed and approved non-healthcare staff protocols to utilize when nursing staff are not on-site. Two protocols identify the use of OTC medications for minor complaints. The RN staff have an OTC medication lock box for the supervisory staff to utilize when nursing staff are not on-site. Each applicable youth's MAR documented the youth and staff initials validated the youth took the required dosage. The supervisory non-healthcare also confirms the allergy status of the youth and any current perceived side effects or adverse reaction to the medication. Informal staff interviews indicated the medical staff were trained on the six rights of medication administration. Reviewed MARs supported the RN staff conducted side effect monitoring daily.

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 combined infection and exposure control plan signed by the program director (PD) and a designated corporate official which was last updated on September 1, 2018. The program's plan addressed risk assessment, methods of compliance, engineering, work-place control, and training requirements to provide a safe environment for youth, staff, and visitors. The program's exposure control plan is written in accordance with the Occupational Safety and Health Administration (OSHA) Rule 29 CFR Part 1910, 1030, and guidelines from the Center for Disease and Prevention (CDC) for testing, decontamination, sterilization, and proper disposal of sharps and bio-hazardous wastes. The program plan procedures include all the required elements. The exposure control plan included a comprehensive process for needle stick post-exposure evaluation and the plan is available to all staff. Emergency needle sticks information was posted in the clinic. The program reports there were no incidents involving a

contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, whichever number is less. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. An interview with the registered nurse (RN) indicated there were no instances in which the local county health department, CDC, and or the Department's Central Communications Center (CCC) should have been notified of an infectious disease. A review of the training documentation found six of the seven interviewed staff members received training in the program's infection control site-specific plan. In addition of the plan, the program has an extensive policy and procedures regarding control and management of methicillin resistant staphylococcus aureus (MRSA). An interview completed with the RN found the program's RN provided all youth in the program monthly training in infection control. During an interview with the PD, it was revealed the exposure control plan is in master control and in the medical office and the plan is reviewed monthly.

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

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

Standard 5: Safety and Security

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

The program maintains a written policy and procedures with respect 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 lobby, youth living areas, and hallways. Youth and staff observations were conducted each day throughout the week of the annual compliance review and reflected during class, lunch, recreation time, and movement. Staff were positioned to ensure proper supervision and to ensure there were no physical obstructions in their view of the youth. Observations made throughout the annual compliance review week included youth movement from classroom to classroom, classroom to cafeteria, and from dormitory to the outdoor recreation area. 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 supervising staff each day and reflected staff were aware of how many youth they were supervising and understood the program's procedures to take when there is a discrepancy in youth counts. Staff reported when a youth count cannot be reconciled; all movement is stopped, no one may enter or leave the secure area, a recount of all youth is conducted, and staff notify master control or the shift supervisor. Formal and informal resident counts are consistently completed throughout each day. Observations found the program staff interacting positive 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 also outlined in the youth handbook, offering a detailed explanation of the program's system, rules, and expectations. A formal interview conducted with the program's assistant program director (APD) confirmed the program's BMS has not changed since the last annual compliance review. The BMS is a four level system which is a coordinated 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 proceeds to progress their way up the four levels. The four levels of the BMS includes a junior varsity level, varsity level, college level, and pro level. 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 which includes responsibilities, expectations, and level advancement. 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. Reviewed documentation reflected daily point sheets are totaled each day and at the end of each week. The program maintains a monthly nightly privilege calendar and system for positive reinforcement opportunities. The program's student council members along with administrative staff develop a monthly nightly incentive calendar filled with fun and meaningful activities. 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 privilege, the program has an incentive each Monday and Friday labelled "Marvelous Monday's!" and "Fantastic Friday's!" respectively. On Monday's, an incentive is given to any youth who went the entire weekend without incurring any major rule violations. On Friday's, 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 to, displaying good manners, and/or being patient; 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 modules to have lunch of their choice with a treatment team member. A review of seven 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 reflected each youth signed the youth handbook to acknowledge their receipt upon admission into the program. A review of seven pre-service training records and seven 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. Monitoring of the BMS reflected 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 procedure (FOP) coupled with an interview with the program's program director (PD) 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. Seven 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 constantly 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 assistant program director (APD) 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 receive 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 program's APD reported the BMS is monitored in the program's monthly meetings and performance evaluations to ensure it is being administered fairly and consistently. Program management provides updates and feedback on the staff's use of rewards and consequences regarding the BMS when noticed, during staff meetings, and during shift briefings. Seven staff were interviewed and stated their supervisors provide feedback to staff regarding the implementation of the BMS immediately or when having knowledge of a situation. Seven 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. Seven interviewed youth confirmed they are never allowed to punish another youth. Four youth rated the program's BMS as fair, two youth rated it as very good, and one youth rated it as 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 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 utilizes a ten-minute check log to document the check while the youth are in their sleeping quarter. A formal interview was

conducted with the assistant program director (APD) and it was 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. The video system can store video recordings for up to thirty-days. If there are any issues with the cameras, the program utilizes Florida State Security for service repair. The camera system on the program's Dolphin side has two DVR systems which record continuously throughout the day while the camera system on the Hurricanes side of the program has two DVR systems which record on a motion activated camera recording system. Reviewed documentation of the program's ten-minute check log forms reflected staff documented the actual time of the room check and provide 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 by staff and were documented accordingly in real time. In some instances, staff were observed entering the youth's room to conduct the check. During an interview with the APD, it was advised sometimes the staff cannot see the youth's skin or body part due to being covered by their comforter. As a result, to ensure fidelity the staff may enter the room to ensure the youth is observed to be safe and sound. Six of seven 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 has a policy and procedures in place to ensure youth are continuously accounted for through a system of physically counting youth at various times throughout the day. The program conducts and document youth counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots. 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 is conducting 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. Seven staff were interviewed and confirmed the importance of emergency counts and how often counts must be performed, which aligned with the program's policy. 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 regarding 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 documentation of population counts, perimeter checks, emergency situations, incidents, transports, removal of youth from population, downgrading youth from precautionary observation (PO) to standard supervision, 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 were legible and written in ink with no erasures or white-out. The program also conducts staff briefings prior to the beginning of each shift which are being recorded in the logbook. Observation of a shift change meeting reflected incoming staff are briefed on the previous shift occurrences and incoming staff sign and date the shift report for 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 governs 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 submit 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 and administrative staff such as supervisors, the assistant program director (APD), and the program director (PD). 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 APD were interviewed and advised damaged keys are turned over to master control and maintenance personnel and administration is notified to have the key replaced. Staff must complete a damaged key form. Seven interviewed staff understood the key control processes including how keys are assigned, missing/lost keys, damaged keys, and restricted keys. The master control operator and the APD are advised if lost keys have not been found within two hours, the incident is reported to the Department's Central Communications Center (CCC).

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 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/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. Youth receive a youth handbook upon their admission to the program. 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, or devices capable of taking photos, and/or audio/video recordings. A review of the master control logbook found unannounced room searches are conducted routinely and perimeter searches are 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 search

reports and the safety perimeter check inspection reports for the past six months verified searches and facility checks are conducted daily on each shift. Any illegal contraband will be turned over to the local police department. An interview with the assistant program director (APD) reported, discovery of unauthorized contraband is confiscated, either discarded, returned to the original owner, mailed to the youth's home, or stored and returned to the youth upon their 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.). Observation of youth frisk searches before and after groups found no contraband were confiscated. During the annual compliance review week, the program did not have any youth transport, admissions, youth returning from off-campus activities, or visitors; therefore, persons entering from outside of the program were not observed. Reviewed documentation and observation of the program's practice of searches and full body visual searches following movement from one area of the facility to another and after activities was observed. Parent/guardians are notified of searches during visitation by the parent/guardian intake letter and packet containing the youth handbook and program rules which is mailed to the parent/guardian at the time of the youth's admission. Observation 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. Seven interviewed staff confirmed the process for conducting searches by responding youth are searched after movement, upon return from off-campus activities, at random and if a youth is suspected in possession of lost property. Seven 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 maintains a written policy and procedures in place for vehicles and vehicle maintenance in order to operate in a safe manner. The program has two Department vehicles used to transport youth at the program. The Department identifies one van as van number three and the other van as van number nineteen. Van nineteen was pulled and/or surplused from another Department program.. 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 November 14, 2018 and documentation for van number nineteen had its annual inspection completed on November 1, 2018. According to the assistant program director (APD), vehicle

nineteen is sent out for quarterly inspections. Observation 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 were no youth transported to the program or transported off-site. A formal interview was conducted with both the APD and the recreational therapist, each 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 assistant program director (APD) and the recreational therapist, confirmed the program has a minimum of two staff for each transport and a staff person always occupies the rear passenger's seat area. Staff are not allowed to transport youth in their 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 licenses. 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 APD. An interview with the APD 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 every hour when out on a transport with youth to provide a formal headcount and a status update on their location. 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 also stores an emergency binder in each van which contains a current copy of an Authorization for Evaluation and Treatment (AET) form 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. A formal interview with the APD and the recreational therapist explained the practice of the staff-to-youth ratio of one staff to every five youth is always 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 has a written policy and procedures requiring weekly safety and security audits of the physical plant, grounds, and perimeter. The program's policy meets all the requirements of Florida Administrative Code 63E-7.013(5). The program's assistant program director (APD) or designee is responsible for conducting safety and security audits every seven days. Reviewed documentation reflected staff utilize 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 APD combined with reviewed documentation confirmed the APD reviews all weekly safety inspection forms weekly.

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 also address the issuance, inventory, control of equipment and tools, and staff shall report any discrepancy to the program director (PD) or designee for immediate follow-up action. The program prohibited tools such as machetes, bowie knives, or any long blade knives. The program's policy also addresses missing and/or lost tool procedures. According to the assistant program director (APD), the program identifies the physical plant manager as the designated tool control manager. The physical plant manager replaces and disposed of tools as needed. The physical plant manager completes a Tool Replacement form and submits it to the program director for approval to purchase a replacement. There was no documented practice during this review period. Observed tools found each were securely stored when not in use, marked for easy identification, and inventoried prior to being issued for work and at the conclusion of work. Observations of the tool storage area indicated it was organized and the physical plant manager confirmed youth are not allowed to utilize any class A tools. A review of seven staff training records and seven youth case management records indicated staff and youth are trained on the safe use of class B tools. Seven interviewed youth confirmed they use mops and brooms only. One of the seven interviewed youth stated they can use an axe if a youth work up to a certain level in the program. A follow-up question for this issue found the youth has never used an ax nor has witnessed another youth and/or staff use an ax.

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 composed strategy and methods 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 at the time of their admission and every thirty days thereafter. Reviewed documentation confirmed assessments were completed on each youth prior to the youth utilizing class B tools. Class B tools can be used only by youth who have been identified and approved on their latest youth risk assessment. Observations of staff confirmed the search practice procedure was conducted for youth who were issued a class B tool, tool distributions, and collections when youth concluded cleaning the hall floor. Seven 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, which are inventoried. The program restricts tools to only the repairman using the specific tools. 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 program director (PD) or assistant program director (APD) 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 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 random selection of the completed project invoices submitted to the program by the vendor validated the program's practice of having outside contractors enter the secure area of the facility with an inventory of tools both entering and leaving the facility and the worker's signature on the contractor agreement form provided by the program.

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 May 17, 2019. 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 which included the beginning and ending time and the nature of the drill. Reviewed documentation confirmed the program had unannounced fire drills and COOP drills on each shift in accordance with their COOP. An interview with the assistant program director (APD) reflected fire drills and COOP drills are to be completed monthly for each shift. Seven interviewed youth confirmed they had been instructed on what to do in the case of a fire. Interviews conducted with seven 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 include a coordinated disaster plan. The plan provides for the basic care and custody of youth in the event of an emergency or disaster and continuity of the continuation of services ensuring the safety of staff, youth, and the public. The plan outlines a procedure 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 May 17,2019. The COOP is located in master control and is readily available to staff members. The program has identified the various location 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 also 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 vent the program has to vacate due to an emergency or disaster. A formal interview with the assistant program director (APD) confirmed a copy of the COOP is located in master control and both program director's (PDs), and APD office. Observations including the APD interview confirmed the program maintain 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 the youth name, a photograph, Department identification number, admission date, date of birth, gender, and race, name, address, and parent/guardian contact information of name, address, telephone number of the person with whom the youth resides, and their relationship to the youth, 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 has a composed strategy and methods 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 to be securely stored. Observations made 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 inconsistencies noted. A formal interview with the assistant program director (APD) confirmed the APD, the program director (PD), and physical plant manager are the only individual with access to the storage area.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	**Limited 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 of harmful chemicals and materials. The physical plant manager maintains strict control of flammable, poisonous, and toxic items and materials stored in the program. Youth are limited from the zone where poisonous items are stored. An informal interview with staff reported 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 moping the floor. The youth were being monitored directly by a direct care staff member and was searched after completing each work detail. One of the seven interviewed youth stated they have used paint. Seven youth stated they have used laundry soap and two youth stated they have used window or toilet cleaner. According to the assistant program director (APD) the 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 being conducted as outlined in F.A.C. 63E-7.109(3). The physical plant manager resigned in April 2019; therefore, no Preventive Maintenance Checklist was available from April 12, 2019 through July 2019. The new plant manager was hired on July 30, 2019.

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 of unused flammable, poisonous, 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. An interview with the assistant program director (APD) confirmed there were no incidents of a chemical spill from January through August 2019. There were no disposal of flammable, toxic, and poisonous materials. The physical plant manager disposes all hazardous; such as old paint, materials paint, thinner, and stripper when necessary at an off-site business.

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 posted in the main lobby, Dolphin dorm, Hurricane dorm, and master control. Informal interviews with staff and youth confirmed the program also allows alternative visitation arrangements with parent/guardian. However, it must be approved by the assistant program director (APD) or program director (PD). The program has a practice of searching incoming and outgoing mail in the presence of the youth. Seven youth were interviewed and stated they were provided the opportunity to communicate with their family by visitation, mail, or telephone.

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 confirmed 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 confirmed 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 confirmed the program does not use controlled observation; therefore, this indicator rates as non-applicable.

5.26 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 maintains a written policy and procedures to conduct an on-going safety planning process for each youth. The safety plan shall be designed to identify stimuli both positive and negative effects on the youth. An informal interview with the master control operator confirmed the safety planning notebook is located in master control. Reviewed documentation found the youth safety plans were developed during the admission process and found all required topic areas were included. All youth safety plans contained warning signs, youth's baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies

preferred by the youth, and debriefing preferences. A formal interview with the assistant program director (APD), reported all youth receive a safety plan on the day of admission to the program. Reviewed documentation supported the treatment team met on the day of each youth's admission to discuss and develop the youth's safety plan. Each reviewed safety plan included current clinical assessments and/or screening assessments conducted at admission. Reviewed documentation of seven youth safety plans found they were not being updated every thirty-days or following any significant behavioral or mental health event identified by the youth's intervention and treatment team. However, the APD stated each youth's safety plan is discussed during team meeting and shift briefings and documented as such. The youth safety plans were maintained in master control and in the youth case management record.