STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Charles Britt Academy
Sequel TSI of Florida, LLC
(Contract Provider)
3001 26th Street Avenue South
[St. Petersburg,], Florida 33712

Review Date(s): May 19-22, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Marvin D. Bliss, Office of Program Accountability, Lead Reviewer (Standard 1)
Brenda Comadore, Office of Program Accountability, Regional Monitor (Standard 4)
Melissa Johnson, Office of Program Accountability, Central Region Deputy Supervisor (Standard 3)
Gregory MahoumNassar, Office of Program Accountability, Regional Monitor (Standard 5)
Stephanie Shay, Office of Program Accountability, Deputy Supervisor, (Standard 3)
Jonathan Thompson, Office of Program Accountability, Regional Monitor (Standard 2)

Program Name: Charles Britt Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Pinellas County / Circuit 6
Review Date(s): May 19-22, 2020

MQI Program Code: 1279
Contract Number: 10092
Number of Beds: 28
Lead Reviewer Code: 173

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

Overall Rating Summary

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

	Standard 2 - Assessment and Performance Plan	
2.01	Initial Contacts to Parent/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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Charles Britt Academy is a twenty-eight-bed program, for fourteen to eighteen-year-old males, located in Saint Petersburg, Florida. The program is operated by Sequel TSI of Florida, LLC., through a contract with the Department. The program provides comprehensive Substance Abuse Treatment Overlay Services (SAOS). The youth receive substance abuse treatment, social and life skills, vocational training, and on-site educational classes. In addition, the program fosters youth by providing delinquency intervention services for the youth, which include 'Impact of Crime' (IOC), 'Thinking for A Change' (T4C), and Things my Father Never had with Me. Additional treatment services provided includes individual counseling, group therapy, and family therapy seven days a week. Program administration is comprised of an executive director, an assistant executive director, a human resources manager, a licensed clinical director and two therapists, a food service manager, two case managers, a transition specialist, a recreation therapist, a full-time registered nurse, a part-time registered nurse, two food service workers, a lead teacher including four teachers, three shift supervisors, and fifteen direct care staff. The layout of the program includes one building. The program has twenty-one cameras, all of which were operational at the time of the annual compliance review. At the time of the annual compliance review, the program had one vacant position; a part time nurse. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of some specific indicators or elements were unable to be completed or were completed utilizing video recordings during this fiscal year. Off-site supplemental reviews will be conducted as desk audits throughout the remainder of this fiscal year.

Standard 1: Management Accountability

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

The program has a policy and procedures for initial background screening. The program had nineteen newly hired staff since the last annual compliance review who required an initial background screening. There were no new volunteers requiring an initial background screening since the last annual compliance review. A review of nineteen staff records found eighteen supported background screenings were completed, by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each staff's date of hire and/or contact with youth or access to confidential information. One new staff was hired prior to their background screening being completed for training and was not involved with the youth. Each newly hired staff's criminal history and the Department's Central Communications Center (CCC) Person Involvement Report were reviewed by the program's human resources manager prior to each date of hire. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's BSU on January 21, 2020, meeting the annual requirement. Reviewed documentation supported the teachers are employed by Pinellas county and received an annual background screening on January 31, 2020. The program had twenty direct care staff who required a pre-employment assessment. Reviewed documentation found a pre-employment assessment was completed by each newly hired direct care staff and a copy of the passing score was maintained in each staff's personnel record.

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

The program has a policy and procedures addressing the rescreening process for staff every five years based upon their original date of hire. Rescreening documentation must be submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten days prior to the staff's five-year anniversary date. The program maintains a staff roster which is reviewed routinely by the program's human resources manager to determine when a five-year rescreening is required. The program had no five-year rescreen required since the last 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 trama responsive practices.*
- *The program shall complete or schedule a TRACE self-assessment.*

The program has a policy and procedures which addresses a code of conduct. Observation of the facility during the annual compliance review found the telephone numbers for the Department's Central Communications Center (CCC) and the Florida Abuse Hotline posted throughout the program. The executive director (ED) stated youth have unimpeded access to the Florida Abuse Hotline and the CCC for youth who are eighteen years of age. If a youth requests to call the Florida Abuse Hotline, the youth care worker allows the youth to use the phone, which is a direct line to the Florida Abuse Hotline, youth eighteen years or older will have the CCC called by staff if requested. Five interviewed staff confirmed this practice. There were no internal incidents requiring report to the Florida Abuse Hotline or the CCC. There are no current incidents pending a conclusion of an investigation. The ED stated once an allegation against staff is made, the staff is immediately removed from youth contact and an internal investigation is conducted. Action may include verbal warnings, written disciplinary action, suspension, and/or termination. The program completed a fiscal year 2019/2020 TRACE self-assessment on April 30, 2020. Five interviewed youth reported feeling safe in the program and were not deprived of basic needs at any time. In an interview, all five youth reported staff are respectful when speaking to them. None of the five youth reported being stopped from calling the CCC and the Florida Abuse Hotline when requested or hearing staff use profanity. Two of five youth made comments: One youth reported if you are feeling down staff talk to you and there are lots of people to help you. Another youth reported feeling protected and the staff makes sure we are safe. Three of five youth reported they feel safe. Five interviewed staff reported never hearing a co-worker use profanity towards a youth or telling a youth they could not call the Florida Abuse Hotline. All five staff interviewed could state the procedure for calling the CCC and Florida Abuse Hotline.

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 maintains a policy and procedures which addresses management's response to allegations. A review of incidents since the last annual compliance review found the program had no incidents of abuse allegations reported during the annual review cycle. In an interview, the executive director (ED) reported staff are made aware of the abuse reporting protocols during pre-service and annual in-service training. The ED further stated the telephone numbers to the Florida Abuse Hotline and the Department's Central Communications Center (CCC) are posted throughout the program for easy reference. Five staff interviews indicated they will give a phone call to any youth requesting to call the Florida Abuse Hotline or CCC.

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

The program has a policy and procedures regarding reports to the Department's Central Communications Center (CCC). The program had ten incidents reported to the CCC during the review cycle, of which five were reviewed. Documentation validated each incident was reported to the CCC within the mandatory two-hour timeframe and in accordance with CCC reporting procedures. The program maintains a master binder for containing reports to the CCC. A review of logbooks for the past six months supported all reports were documented. A review of internal incidents for the past six months determined there were no incidents which should have been reported to the CCC but were not. All five interviewed youth indicated they never have been stopped from reporting abuse since they have been in the program.

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

The program has a policy and procedures addressing Protective Action Response (PAR). The program has a PAR plan approved by the Department's Office of Staff Development and Training on January 2020. The program had one PAR report completed in the past six months and one report was reviewed. Documentation found each report included a review by a PAR certified instructor and documented a post-PAR interview conducted within thirty minutes after the incident. A review of the PAR incident report and comments by the executive director (ED) or designee within seventy-two hours of the incident, was found in the PAR report. The reviewed report did not require a PAR medical review. Documentation confirmed the report was reviewed within the timeframe and processed by a team leader and a PAR instructor to determine if use of force was consistent with policy in the PAR report. The reviewed report did not require a report to the Central Communications Center (CCC), and there was no

documentation to support any involved youth made a report to the Florida Abuse Hotline. Logbooks were reviewed, and documentation did not reveal any additional PAR incidents occurred. The program experienced a decrease of PAR incidents since the last annual compliance review. The program's PAR rate during the annual compliance review period was .48, which is lower than the statewide Residential PAR rate of 2.28. In an interview, the ED stated PAR reports are reviewed during morning management meetings to ensure staff compliance with PAR protocols. Any incident of excessive or unnecessary force is immediately investigated by the program.

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

The program has a policy and procedures addressing pre-service training. The program maintains a pre-service training plan and calendar for all new staff which was submitted to the Department's Office of Staff Development and Training on December 20, 2019 and approved on January 13, 2020. One hundred twenty hours of pre-service training, including one week of Proactive Action Response (PAR) training with certified staff, is conducted through web-based and instructor-led courses. Five staff training records were reviewed for pre-service training. Five reviewed records found each staff completed the certification process within 180 days of hire. Reviewed documentation supported all five staff completed all required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. All five of the reviewed training records supported each staff completed the required suicide prevention training prior to contact with youth. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro). The training coordinator confirmed staff performing in all positions receive the same pre-service training, apart from the nursing staff.

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

The program maintains an in-service training plan which was submitted to the Department's Office of Staff Development and Training on December 20, 2019 and approved on January 31, 2020. Five applicable staff training records, including three team leader's training records, were reviewed for in-service training. Each reviewed staff training record documented the staff exceeded the twenty-four hours of in-service training requirements. Each staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff completed training in professionalism and ethics, including standards of conduct and active shooter training. Five staff completed training in suicide prevention inclusive of two hours web-based and four hours instructor-led. Three team leader training records were reviewed for completion of eight hours of management and team leader training inclusive of management, leadership, personal accountability,

employee relations, communications skills, and fiscal. Reviewed documentation supported each team leader exceeded this requirement. All trainings were delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro). The program's contract was reviewed and confirmed there were no additional training requirements.

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

The program has a policy and procedures to address the grievance process. Youth are provided a handbook upon admission which outlines the youth grievance process. The program uses a three-tier level grievance process consisting of informal, formal, and appeal phases. The program uses the speak out forms as there way of filing an in-formal grievance. Observation during the annual compliance review found grievance forms and speak out forms are in the hall way leading out of the dormitory. If a youth does wish to file a grievance, the youth completes the grievance form and places it in the grievance box located outside the dormitory. The team leader who gathers the forms once a day has seventy-two hours to respond to the youth in writing. Should the youth feel the initial response from staff does not adequately address the youth's concerns, the issue is presented to the next level of management staff. The final level is the executive director (ED) and/or designee who will then provide their written response to the youth within seventy-two hours for the appeal level of the grievance process. An interview with the ED confirmed this practice. A review of the program's grievance binder reflected one grievance being filed within the past six months, of which one was reviewed. Documentation found the grievance was resolved in the informal phase. No grievance was appealed and had to be resolved by the ED or designee within the required timeframe. The team leader responded the same day the grievance was filed. The first phase of the grievance process is the youth completes the speak out form as an alternative to filing a formal grievance form, and the second phase is for the youth to meet with the shift team leader, once completing the formal grievance form. The final phase includes a review by the ED or designee if the youth is not satisfied with the resolution proposed by the shift team leader. The program maintains a grievance binder with all the grievances and speak out forms filed for a year. Five interviewed staff were able to describe the program's grievance process. Five youth were interviewed, and each knew how to file a grievance and stated they could ask for assistance in completing the form if necessary. A review of five in-service training files found all receive the grievance training update annually. A review of five pre-services training files found all received grievance training during their pre-service training.

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 delinquency interventions through evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. The evidenced-based interventions are those designed to reduce the influence of risk factors related to re-offending behavior. The program conducts Living in Balance (LIB), Impact of Crime (IOC), Thinking for A Change (T4C), and the Council for Boys and Young Men groups twice a week. An interview with the executive director (ED) confirmed delinquency interventions are delivered by trained staff. A review of each of the designated staff's training records reflected all staff had the appropriate education and qualifications to be hired in their respective positions and completed the required training to facilitate the delinquency intervention groups. The program's daily schedule reflects delinquency intervention groups are conducted seven days a week pursuant to the program's contract and reviewed sign-in sheets confirmed this practice. A review of five youth individual performance plans supported each youth had at least one delinquency intervention goal addressing an identified priority need, and reviewed group sign-in sheets validated ten youth were participating in IOC groups. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observations of a delinquency intervention group was not possible. In an interview, the ED reported youth are matched with staff, therapists, and case managers based on their individual assessments.

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

The program has a policy and procedures which provides interventions and instruction focusing on developing life and social skill competencies to youth through classroom and group instruction, hands-on experiences, and role model by program staff. The program's activity schedule allows for scheduled interventions for youth to receive life skills training pursuant to the contract. Qualified staff present The Council for Boys and Young Men, Life Skills Training (LST), and Things my Father Never had with Me to youth. An outside agency SHARPS of Pinellas county conducts Life Skill education for boys monthly. A review of five youth individual performance plans and sign-in sheets validated they are participating in life skill training for anger management, communication, critical thinking, interpersonal relationships, and communication as indicated in each youth's identified priority needs seven days a week by group facilitators trained to deliver their respective curricula. Reviewed documentation in each staff's training records confirmed each has received the required training to deliver the curricula. In an interview, the ED stated all youth in the program participate in life skills groups. Five youth were interviewed and all five stated they attend groups daily. All five-interviewed youth reported learning new skills such as anger management, decision making skills, and how to process

grief. In addition, each of the five-youth stated they practice the new skills during group and individually during their daily routines.

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 delinquency interventions through evidence-based principles and practices of restorative justice. ThThe program utilized Impact of Crime (IOC) and Thinking for a Change (T4C) as the delinquency intervention model of restorative justice with each youth placed in groups according to their identified individual needs. This practice was confirmed by the executive director (ED). IOC is a closed group and at the time of the annual compliance review, there was one cohort running, as scheduled. T4C cohort ended on May 16, 2020. An Interview with the program's ED confirmed delinquency interventions are delivered by staff with the required education and qualifications to be hired in their respective positions. It was noted in staff training records staff facilitating IOC and T4C received the required training. The program invites guest speakers who are also victims to speak to the youth in conjunction with victim videos provided with the IOC curriculum. A review of five youth individual performance plans and random group sign-in sheets validated they are each participating in IOC groups currently. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observations of a restorative justice awareness group was not possible.

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

The program has a policy and procedures which addresses gender-specific programming for a male population as required by the contract. The program identified Things my Father Never had with Me as their gender-specific curriculum. The curriculum was facilitated by trained staff during this annual compliance review period. A review of each of their training records confirmed each of the staff was certified as a facilitator for Things my Father Never had with Me. The daily activity schedule allows for the Things my Father Never had with Me to be offered on a regular basis. The executive director (ED) indicated in an interview all youth will participate in the evidenced-based groups, which addresses many aspects of the characteristics of the program's population. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observations of a gender-specific programming group was not possible.

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

The program has a policy and procedures regarding entering alerts in the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. An interview with the program's executive director (ED) confirmed the alert reports and internal alerts are distributed and reviewed by shift supervisors and administration, daily. Upon review of the alert board and list, the supervisors discuss the alerts with all working direct care staff, at each shift briefing. The alert system includes one white-board, which is maintained in the administrative area. The whiteboard was found to contain key alert information, including youth who are a security or safety risk, a gang member or suspected gang member, youth with health-related concerns, youth with food allergies or special diets, and youth with suicide or mental health alerts. The alert board is updated when a youth enters the program and immediately, whenever any changes happen during a youth's stay. A current alert list is issued to team leaders and reviewed with living unit staff, the kitchen and the medical clinic. This list is maintained in the administrative area, which is updated daily. A review of the logbook confirmed alerts are a standing agenda item. The medical, and mental health and substance abuse staff, as well as the case managers, and administration enter and update any applicable or critical alerts in the JJIS alert system and the program's internal alert system. If a youth with an alert is admitted to the program after a shift's briefing, the appropriate department staff updates the internal alert list, white board, and the JJIS alert system and immediately distributes the new list to the team leaders, administration, and the kitchen, at which time the information is verbally communicated to direct care staff. A review of five youth records found each was applicable to have an alert entered into the program's internal and the JJIS alert system. Reviewed documentation supported each had the appropriate alert entered into the internal alert system. Five interviewed staff confirmed staff are notified of alerts during each shift's briefing, are required to review the alert book and sign the logbook under alert review.

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

The program maintains separate hardbound binders for case management, healthcare, and mental health and substance abuse records, all of which are maintained by the respective departments. Observations of the records found each marked "confidential" and secured in assigned offices when not in use. Reviewed records contained all the most recent information in chronological order. Within each reviewed record, information was separated into clearly labeled

designated sections for legal, demographic, case management with treatment plan and interventions, and correspondence, along with a miscellaneous tab.

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

The program has established a youth advisory board which allows an avenue for youth to discuss issues, concerns, and suggestions for possible changes in practice. The youth representatives are chosen by the treatment team, rewarding youth who have demonstrated positive behaviors and compliance with treatment goals. The youth advisory board meets quarterly to discuss issues such as food service including special meals, behavior incentives, specialized programming, holiday and community service activities, abuse protocols, healthcare, along with an open floor forum. Youth advisory board members are the liaisons between the youth and program administration. An interview with the executive director (ED) and reviewed sign-in sheets validated meetings are held quarterly. Representatives of the program's management team and the recreation therapist monitored the meetings and offered advice from the management perspective. In an interview, the ED reported the youth advisory board helps youth feel a part of the process with valued opinions and input. In addition to the youth advisory board, all youth participate in weekly community meetings to discuss any presenting issues they may have during their day. In addition, youth also complete quarterly surveys which the results are compiled by the compliance department and discussed during all staff meetings. Youth are also encouraged to utilize "Speak Out" forms as an avenue to convey suggests or complaints. Five interviewed youth validated the program conducts weekly community meetings and the use of "Speak Out" forms and they can take their issues to the advisory board members.

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

The program has a policy and procedures to address a community advisory board. The program has a community advisory board, which meets quarterly. The board is comprised of local law enforcement, local school board, the local judiciary, a parent/guardian of a youth previously in the program, the business community, the faith-based community, and a child victim advocate; all required disciplines are represented on the board except for a member of the lesbian, gay, bi-sexual, transgender, queer, intersex (LGBTQI) community. The program maintained invitation letters being sent out quarterly to local LGBTQI establishments and support groups asking for help recruiting a representative for their advisory board. There was a community board meeting each quarter since the previous annual compliance review. The program mailed letters to the board members to remind them of the meeting. The meeting minutes and sign-in sheets for board meetings were reviewed for the six months prior to the annual compliance review; there was documentation in the form of agendas and sign-in sheets to support meetings were held quarterly. A member of the community advisory board was interviewed during the annual compliance review; he is a member of the faith-based community. He reported his main focus is to recruit members of the faith community to visit the program on a weekly basis to mentor the youth. The board member reported arranging guest speakers for the youth. The church board members provide special events for the youth who have earned the privilege to go on outings. The executive director was interviewed and reported the program's board assists with special

events, community involvement, and program improvement. This was validated through a review of advisory board meeting minutes.

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

The program maintains a policy and procedures regarding the program's planning process and to ensure provisions for adequate staffing and open lines of communication among staff. The program conducts daily debriefings each day on each shift, additionally the program holds weekly management meetings. The program conducts all-staff meetings monthly. A variety of topics are discussed including the program's policy and procedures, as well as the parent/guardian and youth survey results and the Comprehensive Accountability Report (CAR). A review of sign-in sheets from the all-staff meetings for the past six months indicated staff meetings were held monthly. The meeting's agendas and minutes reflected staff were informed about multiple subject areas from operations, risk management, and case management, while allowing each specific department the opportunity to present their concerns. An interview with the executive director (ED) indicated staff are kept informed through shift briefings and monthly staff meetings. Active recruiting is ongoing to address staff vacancies. To increase staff retention and employee morale, the program identifies an employee of the month and year, as well as conducts various employee appreciation events and tuition assistance. Youth and parent/guardian surveys are conducted during visitation and upon the youth's release from the program. An interview with the ED indicated the outcome data used by the program are the parent/guardian surveys, feedback during treatment team, and feedback during individual and family sessions. Random review of surveys included feedback for case management, mental health, food, and medical services. The information is then shared during manager's, and all staff meetings and incorporated into the program's planning process. Two of five interviewed staff reported communication in the program was either good or very good. Two of five staff stated communication is fair. Each staff validated information is conveyed during shift briefings and all staff meetings.

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

The program has a policy and procedures addressing the evaluation of staff performance. Performance evaluation measures are completed annually for in-service staff and at the initial ninety-day probationary period for pre-service staff, addressing areas including basic job knowledge, reliability, attendance, education and training, initiative, adherence to policy, interpersonal relationships, judgement, competency, and goals achieved. The evaluation process also includes best practice elements adapted by the program. Evaluations are unique for the specific types of staff positions at the program. Staff who facilitate groups are evaluated for their skills at facilitating a delinquency intervention, and all staff are evaluated on the implementation of the program's behavior management system. Once reviewed by staff, they are given the opportunity to provide their signature on the evaluation form along with any comments. The employee performance evaluation practice was confirmed in an interview with the executive director (ED). Five personnel records were reviewed to include, youth care workers, a supervisor, a case manager, and a therapist, and each included the job description for the applicable specific position, applicable performance evaluations, education records and degrees, and a copy of the acknowledgement for the program's code of conduct. Five staff were

interviewed and four stated they receive a performance evaluation annually, one stated they receive a performance evaluation monthly.

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

The program has a policy and procedures regarding recreation and leisure opportunities for youth. The program employed a recreation therapist who held a bachelors-level degree in sports and exercise science with two (2) years related experience working in a residential facility, as required by contract, during the annual compliance review until May 19, 2020. The program's activity schedule outlines a block of time for daily large muscle activity for youth as well as group time. A separate recreation therapy schedule was found for every month during the review cycle. The program has free time which is time allotted for youth to engage in their chosen leisure activities such as letter writing, television viewing, and board games. Youth are encouraged through recreation, leisure, and recreation therapy to explore interests and engage in constructive leisure activities. Each youth's treatment plan included weekly recreation therapy and high-risk youth were prescribed additional recreation therapy. The recreation groups held during the annual compliance review period covered a variety of topics including meditation and guided imagery, art therapy, Jenga, origami, brain teasers, exploration of leisure activities, health education, and movies. The groups focused on teaching and improving cognitive skill development, flexibility and change, problem solving, relationship building, teamwork, and communication. Youth who have earned opportunities to go off-campus have been able to participate in recreation trips to fish, set up for community events, play laser tag, attend a movie, and other community activities. The program utilizes a monthly student counsel to allow youth the opportunity to provide feedback into programming. Five youth were interviewed, and each reported they receive varied opportunities throughout the day for mental and physical exertion. Each youth further reported they received at least an hour of physical activity a day and engaged in activities such as basketball, football, lifting weights, watching television, board games, and reading. Five staff were interviewed and each confirmed the youth receive recreation each day and are offered a variety of opportunities. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this annual compliance review was conducted off-site; therefore, observations of youth recreational activities was not possible.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures which require notification to a youth's parents/guardian, by telephone, within twenty-four hours admission, and by written notification within forty-eight hours. Five youth case management records were reviewed to validate initial contact was conducted with a parent/guardian by phone within twenty-four hours and with written correspondence within forty-eight hours, of admission and all five records contained documents which validated telephone contact with the youth's parent/guardian on the day of admission which documented in each youth's chronological notes of the youth's case management record. In all cases, staff mailed a letter to parents/guardians, the court, and the juvenile probation officer (JPO) within forty-eight hours, notifying the youth was admitted to 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 a policy and procedures which dictates the delivery of program orientation and associated requirements. The procedure details all required orientation topics and describes how each youth is to receive the information. The program orientation covers services available, daily schedule, youth expectations and responsibilities, written behavior management system, availability and access to medical and mental health services, access to the Florida Abuse Hotline and/or Central Communications Center (CCC), program's zero-tolerance policy regarding sexual misconduct, special accommodations available to youth, items considered contraband, performance planning process, dress code and hygiene practices, procedures on visitation, mail, and use of the telephone, expectations for release from the program, community access, grievance procedures, emergency procedures, facility tour, assignment to living unit and room, and medical topics. Each of the five case management records reviewed validated orientation took place within twenty-four hours of each youth's admission to the program. All five youth records included youth initials which confirmed their understanding of program rules and expectations. The program did not have a youth admission during the annual compliance review, therefore, no youth orientation was observed. Five youth interviews conducted confirmed orientation to the program began within twenty-four hours of arrival and the program's rules, procedures, and schedules were all discussed accordingly.

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

The program has a policy and procedures which require 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 discussion with the parent/guardian any information related to the youth's physical or mental heal screening, assessment, or treatment. One of the five case management records selected for review, included youth who turned eighteen years of age at the time or prior to the time of admission. The monitor requested two additional files to gain a sample of three applicable youth records. All three youth records contained a written consent form for youth eighteen years of age. All three forms were signed by the youth and obtained before releasing any information relevant to the youth's treatment, assessments, and screenings to parents/guardians.

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

The program has a policy and procedures which govern the initial classification and reclassification of youth at the program. Youth's Initial classification is to be used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor. Reclassification, if warranted, is conducted prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools or instruments may be used as potential weapons or means of escape, or participation in any off-campus activity. Five case management records were reviewed for classification factors, procedures, and reassessments for activities. Initial classification was administered on the day of admission in all five records reviewed. All initial classification assessment included physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, and criminal behavior. Risk factors were assessed and identified by suicide risk, medial risk, escape risk, and security risk in all five records reviewed. Sexually aggression or vulnerability to victimization was assessed through the Victimization and Sexually Aggressive Behavior (VSAB) screening instrument, were completed on the day of admission in all five records. Three of the youth records reviewed were applicable for reassessments. All youth who were granted increase in privileges or freedom of movement and have participated in work projects or other activities involving tools. The three applicable youth records contained properly filled out reassessment was utilized when considering the reclassification. Additionally, programs internal alert system was properly updated for the three

youth. A review of the executive director (ED) interview confirmed youth's sleeping room placement is determined based on all required factors at the classification meeting.

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

The program has a policy and procedures which require the gathering and sharing of gang information with law enforcement entities. A gang affiliation questionnaire is administered to each youth on the day of admission. The questionnaire is geared to gauge each youth's level of gang involvement. If gang affiliation is identified or suspected upon or after admission, an alert is placed in the Department's Juvenile Justice Information System (JJIS) and then, within twenty-four hours, the information is sent to the juvenile probation officer (JPO), local law enforcement, and law enforcement in the youth's home county. Five youth case management records were reviewed in the original sample, and only one was applicable. The reviewer requested an additional two applicable records and the program provided two extra records for a total sample of three. A review of these records revealed all three records contained validation of proper gang screening, JJIS alerts, and validated proper notification was sent out to all required parties within twenty-four hours of admission, as required.

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

The program utilizes a gang affiliation questionnaire which is administered to each youth on the day of admission. The questionnaire is geared to gauge each youth's level of gang involvement. Youth identified as a criminal street gang member, are affiliated with any criminal street gang, or at high risk for gang membership, are provided intervention programming. Program policy indicates the executive director is personally responsible for ensuring gang prevention and intervention strategies are implemented in the program. The program uses the "Thinking for a Change" curriculum as a gang prevention strategy. Each youth at the program completes the curriculum prior to their release. Additionally, "The Phoenix Curriculum" as the course for gang prevention purposes and/or intervention activities. The program has a gang liaison who is involved in the development and implementation of the program's gang preventions overall strategy.

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

The program has a policy and procedures which dictates an initial Residential Assessment for Youth (RAY) assessment be completed within the first thirty days of admission to the program and be maintained in the Department's Juvenile Justice Information System (JJIS). Policy also dictates a reassessment 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 and maintained in JJIS. Five youth case management records were reviewed, and all contained an initial RAY which was completed within thirty days of admission to the program which was completed in JJIS. All records were applicable for RAY Reassessments, all of which, were completed within the ninety-day time limit, or as needed if a change in interventions were needed prior to the ninety days. All five records contained documentation of the initial assessment and reassessments as required.

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

The program has a policy and procedures which require a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission and maintain all documentation of the initial assessment process in the Department's Juvenile Justice Information System (JJIS) on the YNAS. Five youth records were reviewed, all of which, contained a Youth Needs Assessment Summary (YNAS) which was completed within 30 days of admission to the program. Each YNAS was completed prior to the required timeframe and properly documented the assessment in 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.*	

Five youth records were reviewed for the development of performance plans, each of which, completed within thirty days of admission to the program in all five records. Each treatment team consisted of the treatment leader, youth, an administrative representative, living unit representative, treatment staff, and education staff, as required. Youth performance plans contained signatures from all treatment team members. All five youth performance plans were developed after the completion of the initial Residential Assessment for Youth (RAY), as required. Each of the five plans contained goals which were individualized based on the risk factors and protective factors highlighted in the RAY results. Additionally, all five youth performance plans addressed the youth's top three criminogenic needs. Each of the five performance plans contained action steps for the youth and program staff to complete, target court-ordered sanctions, and transition activities targeted for the last ninety-days; for the youth to reach their goals and target dates. Furthermore, copies of the completed plans were provided to the parents/guardians, youth, juvenile probation officers, and the committing court within ten working days of the plan being completed. Five youth were interviewed, and all were able to articulate the program's treatment process and the specifics of their performance plan goals. Each youth indicated were actively involved in the development of their performance plan and all youth confirmed they received a copy of the plan upon completion.

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 policy and procedures ensuring each youth's performance plan is revised as necessary. A review of five youth case management records indicated each youth's plan had been revised based on newly acquired information. None of the reviewed plans were revised based on their Residential Assessment for Youth (RAY) results. All records verified each youth's performance plan was updated when they demonstrated progress or lack of progress towards completing a goal. The program's practice revealed the treatment team meets formally at least every thirty days to discuss each youth's performance plan, and any necessary revisions are made. Three youth records were applicable for being in transition. All three applicable records documented revisions were made to each youth's performance plan to facilitate transition activities during their last sixty days in the program.

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

The program has policy and procedures to ensure the treatment team prepares a performance summary at ninety-days or less following the signing of each youth's performance plan. A review of five youth case management records validated each youth had a performance summary completed at least every ninety days following the signing of their initial performance plan. Each summary included the youth's status on each performance plan goal, overall treatment progress, academic status, behavior, level of motivation and readiness for change, interactions with peers and staff, overall behavior adjustment to the program, and any significant positive and negative events. Documentation reflected all five youth were afforded the ability to read and add comments prior to signing their performance summaries and each youth was provided a copy of their summary upon completion and the original was filed in their case management record. A review of transmittal documentation in all five records validated each summary was sent to the committing court, youth's juvenile probation officer (JPO), youth, and parent/guardian within ten working days. None of the five youth were involved with the Department of Children and Families. Three reviewed records were applicable for having a performance summary completed prior to the youth's release, discharge, or transfer from the program. All three applicable youth had a completed performance summary which included all the above applicable information, as well as, justification for release. Four of the five youth interviews indicated the youth received a copy of their performance summary sent to the court. One youth said they did not receive a copy. A review of three closed youth case management records indicated the original release summary, along with justification for release was sent to the assigned JPO with the Pre-Release Notification (PRN). All three summaries and PRNs were sent at least forty-five days prior to the planned release date. A signed copy was retained in all three records. The court did not object to the release for any of the three youth. Each record contained documentation showing the program provided written notification to each youth's parent/guardian notifying them of their child's release. Each record contained documentation supporting the Residential Assessment for Youth (RAY) was completed for each youth following approval of their release. No youth were applicable for the Sexually Violent Predator Program (SVPP). No victim notification requirements prior to release, therefore, supporting documentation of mailing the victim notification letters at least ten days prior to the youth's release was not applicable.

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

The program has a policy and procedures to provide for parent/guardian involvement. A review of five youth records revealed extensive parent/guardian contacts were made throughout the various stages of treatment and case management services provided. The program documents

in the chronological log contacts with the parent/guardian. Telephone contacts with the parent/guardian were consistently found during the performance planning. The program consistently mailed letter notifications to the parent/guardian for each treatment team meeting. Each formal treatment team was properly documented and reflected the level of parent/guardian participation throughout the services provided for each youth. In total, there were thirty-eight formal treatment team meetings documented in the five youth records. All of which provided evidence of prior notifications to the parent/guardian and mailed documentation at the conclusion of each meeting. In the event of parents/guardians not engaging with the program, case notes referenced multiple attempts of parental contact to involve the parent/guardian their youth's case management services. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observations of a treatment team was not possible. Interviews with executive director revealed parents/guardians are encouraged and expected to participate in their child's treatment from their initial intake until their release from the program. Case management staff are expected invite parents/guardians to participate in their child's treatment by a combination of phone calls and letters. Youth interviews confirmed the program highly encourages parent/guardians to participate 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.	

A review of five youth case management records revealed the program holds a bi-weekly informal and a monthly formal treatment team reviews for each youth. Treatment team members were documented on the treatment team form, and signatures were captured from the youth, case manager, medical staff, therapist, and education staff provided written input in all encounters. Parent/guardian and juvenile probation officers (JPO) participation was noted by telephone in some instances and documentation of coordination efforts were evident when participation was not attained. None of the five youth in the sample were under the care of the Department of Children and Families (DCF) at the time of the annual compliance review. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observations of a treatment team was not possible.

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 maintains 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. A review of five youth case management records found all plans included specific interventions to address the education, academic, mental health, and substance abuse goals identified from other plans and areas of the program. None of the reviewed youth records had Department of Children and Families (DCF) involvement. Therefore, DCF care plans were non applicable.
A review of the five applicable youth records confirmed the inclusion of goals from the Individual Treatment Plan, Individual Academic/Education Plans (IAP/IEP) and program sanctions. The program had no applicable youth for involvement with the Agency for Persons with Disabilities.

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

The program has a policy and procedures to ensure informal treatment team meetings are held with each youth and their case manager at least bi-weekly and formal treatment team meetings occur at least once every thirty days. A review of five youth case management records indicate each youth received a formal treatment team review at least every thirty days. Reviewed documentation in all records included signatures for the treatment team leader, youth, representatives from program administration and living unit representative, treatment staff, educational staff, recreation therapist, and medical representative. The juvenile probation officer (JPO) and parent/guardian's participation, when applicable, was denoted by the statement, 'participated by phone'. Additionally, the youth case management records were reviewed for documentation of informal treatment team meetings. Documentation in all records revealed informal reviews were conducted as required. All formal and informal reviews were documented in each youth's case management record, and included: youth's name, date of the review, comments from treatment team members, brief synopsis of youth's progress, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical intervention, and treatment progress. Each review included Residential Assessment for Youth (RAY) results. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observations of a treatment team was not possible. Five interviewed youth were interviewed, and all reported staff review their performance, to include progress on performance plan goals, positive and negative behavior, and treatment progress. All five youth also stated they were given an opportunity during treatment team meetings to demonstrate skills they have learned in the program.

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

The program has a policy and procedures which govern the facilitation of career education services to youth. The program facilitates a Type 2 career education program which targets personal accountability skills and behaviors leading to appropriate work habits for employment and living standards. The lead educator and executive director interviews confirmed career education process provides various opportunities for career exploration and skill development including, the My Career Shines curriculum, a career assessment/interest inventory, skills confidence assessment, work values assessment, a résumé builder, and teacher directed instruction to support online services. Youth in the program have hands on access to vocational skills and certification through Hands-On Career and Technical Education (C-TECH), APEX on-line, Personal Career Social Development, and the Technology Club. The program continues to provide services to the youth during the COVID-19 pandemic. On April 2, 2020, social distancing measures were established within the program for precautionary measures. Currently, the youth are broken into two groups and the groups rotate on a weekly basis. One group will utilize the computer lab and the other will utilize a classroom to accomplish educational prepared packets. The COVID-19 measures were evaluated while on-site to ensure

youth are receiving educational and career educational services. Five closed records were reviewed for youth receiving career education services. All records contained a sample employment application, résumé, calendar with the career source service appointments, social security card, a state-issued identification card, and training certificates each youth earned while in the program. Each youth's vocational and educational goals were documented and shared with each youth's parent/guardian, case manager, juvenile probation officer, and the youth, which included continued support and supervision after each youth is released from the program.

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

The program has a policy and procedures in place to ensure youth have access to educational services. The program is contracted with the Pinellas County School Board. The instructional schedule is approved by the school district. The educational and career-related program is distributed over twelve months, 250 days of instruction, and a minimum of twenty-five hours of instruction weekly. The program follows the Pinellas county schedule which allots 10 days to be utilized for teacher training and planning purposes and school district professional development. Youth do receive academic credits and certificates earned for training experience. Logbook entries reviewed for specific times and dates reflected youth movement going to and from classes as scheduled with minimal interferences. Minor adjustments have been made in the facilitation of educational services to the youth due to the COVID-19 protective measures which were effective April 2, 2020. Social distancing measures were established within the program for precautionary health measures. Currently, the youth are broken into two groups which rotate on a weekly basis. One group will utilize the computer lab and the other will utilize a classroom to accomplish prepared educational packets. Youth computers can be remotely accessed by teachers enabling video chat providing the individual youth to teacher interaction. The COVID-19 measures were evaluated while on-site to ensure youth are receiving educational and career educational services as required. Five youth were interviewed, and all confirmed educational services are provided on a regular basis with minimal interruptions.

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

Five closed case management records were reviewed, and each contained a detailed education transition plan completed prior to the youth’s release from the program. Each plan was based upon the youth’s specific post-release goals beginning at the youth’s admission to the program, as required. Documentation indicated all required participants, including the youth, parent/guardian, educational staff with access to the district’s management information system, certified school counselor, and post-release/re-entry staff provided input regarding each youth’s education transition plan. A review of the transition plans indicated the services, interventions, and placements were based upon the assessed educational needs, performance, and post-release educational plans for each youth. Each plan identified the individuals specifically responsible for monitoring the reintegration and coordination of support services. All five records were for youth with employability as a transition goal and each plan included provisions for continuation of education or employment, a completed employment application, a résumé

summarizing the youth's education, work experience, and completed career training, valid Florida identification card, and information pertaining to the Career Source Center located near the area in which the youth would be seeking employment. Documentation indicated the youth's case manager and parent/guardian were aware of the post-release discharge 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 policy and procedures in place to ensure the treatment team is planning for each youth's successful transition to the community upon release from the program. A review of five closed youth case management records verified the program held a transition conference for each youth at least sixty-days prior to their anticipated release date. Documentation in all five records confirmed the program invited each youth's parent/guardian, juvenile probation officer (JPO), educational staff, and other pertinent parties to the transition conference. All required parties participated either in person or by phone. Documentation in all five records verified the attendees signed and dated the transition plan and a copy of the plan was sent by mail to the parent/guardians and JPOs who participated by phone, with a request they sign the plan and return it to the program. Documentation indicated the transition conference included a review of transition activities and identification of additional transition activities, including target dates for goal completion and persons responsible for completion. Reviewed documentation confirmed each youth participated in a Community Re-entry Team (CRT) meeting with their case manager prior to their release from the program. Evidence in all five case records indicated an invitation to participate in the CRT was sent out prior to the meeting.

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

The program has a policy and procedures in place to ensure an exit portfolio is assembled for each youth to assist them once they are released back into the community.
A review of five closed youth case management records confirmed an exit portfolio was discussed and initiated for each youth at the transition conference. Each portfolio was completed by the program, verified at the exit conference, and given to the youth upon release. Each record contained a copy of the youth's exit portfolio including a State of Florida identification card, copy of the youth's transition plan, calendar with all upcoming community appointments, education or vocational certificates, education records, school transcripts,

résumé, and sample job applications. Two of the five records contained a birth certificate and no records contained social security cards as some parents/guardians were reluctant to provide these documents. The program made multiple attempts, in both cases, to gain the required documents but to no avail. Reviewed documentation confirmed a copy of the exit portfolio was sent to each youth's juvenile probation officer.

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

The program has a policy and procedures which dictates an exit conference is conducted for each youth, in addition to a formal or informal meeting, to review the status of goals developed at the transition conference and finalize release plans. Five closed youth case management records were reviewed, and documentation indicated each youth had an exit conference which was held after the program notified the juvenile probation officer (JPO) of release and at least fourteen days prior to the youth's release date. All conferences were documented in the case management record and included a summary and review of pending transition goals, the date of the conference, and signatures of participants. Participants included the treatment team leader, education representative, youth, and treatment staff. Documentation of parent/guardian and JPO participation was noted as participating by telephone. Additionally, the review confirmed the exit conference is held separately from transition and Community Re-entry Team meetings.

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 policy and procedures addressing the designated mental health clinician authority (DMHCA). The position description includes the incumbent will act as the facility's mental health and substance abuse authority, responsible for the training and oversight of all substance abuse personnel, provide at least one hour of clinical supervision a week for each unlicensed mental health and substance abuse therapist, ensure compliance with overlay requirements by reviewing the comprehensive evaluations, treatment plans and treatment plan reviews, reviews daily group sign-in sheets, group notes, and any other treatment notes. Completes regular chart audits to ensure all items are filed correctly and completely, integration of a mental health delivery system which meets all state and federal guidelines, provides individual, group, and family therapeutic activities when therapists are off or unavailable, research, responsible for the fidelity monitoring of evidence based services offered, and participation in overall institutional programming, and administration. The DMHCA is available on-call twenty-four hours a day, seven days a week for emergencies. The regional director of mental health for Sequel is a licensed mental health counselor (LMHC) and is the backup for the DMHCA in the event the DMHCA is on vacation or out due to sickness. The LMHC holds a clear and active license which expires on March 31, 2101. The DMHCA reported meeting with clinical staff daily to discuss and supervise services provided and available to provide support and guidance when needed. The DMHCA provides direct care services such as initial behavioral interview, administration of the initial risk assessment tools, completion of Assessment of Suicide Risk (ASR), mental health and substance abuse evaluation and treatment plan, and guides execution of the mock suicide drills. The DMHCA's license expires on March 31, 2021. The review team found no gap in administrative oversight of clinical services during the DMHCA's leave.

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 policy and procedures addressing licensed mental health and substance abuse clinical staff. The regional director of mental health for Sequel is a licensed mental health counselor (LMHC) and is the backup for the designated mental health clinician authority

(DMHCA) in the event the DMHCA is on vacation or out due to sickness. The LMHC holds a clear and active license which expires on March 31, 2021.

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

During the review period, one therapist who provided services left the program and a new therapist filled the position. The therapist who left at the beginning of the review period met the qualifications for the position and completed all training required to provide services to the youth. The program currently has two full-time, non-licensed master's-level therapists. These full-time clinicians provide both mental health services and substance services to youth, under the program's Chapter 397 license. A review of the training records indicated one of the two non-licensed therapists completed all pre-service training and the required twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The second non-licensed therapist has completed all pre-service training but has not completed the required twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services to perform assessments independently. One of the two non-licensed therapists completed five Assessments of Suicide Risk as part of the training while the other non-licensed therapist is still in training and has not completed any assessments. A review of the clinical supervision documentation from the last six months, confirmed two non-licensed clinical staff who provided clinical services in a given week, received one hour of face-to-face, direct supervision which was provided by the designated mental health clinician authority (DMHCA). All supervision was documented to have taken place on-site, with most supervision sessions being in a group setting. Supervision sessions consisted of case consultation, instructions and recommendations to staff, and a sample of staff work which was reviewed. The documentation form for supervision contained all the elements included in the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form for documentation of weekly supervision. All staff members who provided clinical services regardless of job title at the facility were documented to have the requisite training and hold a master's-level degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field.

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

The program has a policy and procedures addressing mental health and substance abuse admission screening. The policy requires the administration of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) to screen every youth upon admission and readmission if they are taken out of the facilities custody for any reason. A review of five records found all screenings were completed entirely in the Department's Juvenile Justice Information System (JJIS), on the day of admission. Each of the five records indicated the MAYSI-2 assessments were completed by the licensed professional mental health staff member, who had

also completed the MASYI-2 training. Three of the five reviewed MAYSI-2 Assessments indicated further assessment was required, while the remaining two youth indicated no further assessment was required. Each of the three records indicated the reason for the referral and each of the three youth received a comprehensive evaluation. One of the three youth were referred for an Assessment of Suicide Risk (ASR). It is the program's practice for all youth who enter the program to be seen by the psychiatrist within the first fourteen days of admission. During an interview with the designated mental health clinician authority (DMHCA), it was confirmed the MAYSI-2 is completed in a confidential manner and all youth admitted to the program are referred to mental health department for the completion of assessments of the MAYSI-2, Substance Abuse Screening Instrument (SASSI), and the Beck Depression Inventory. The DMHCA confirmed following the administration of these assessments all youth are referred for a comprehensive mental health and substance abuse assessment to be completed within twenty-one days of arrival.

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

The program has a policy and procedures addressing mental health and substance abuse comprehensive evaluations. The procedures include each youth receives a new comprehensive mental health and substance abuse and a biopsychosocial evaluation within thirty days of admission. The program, which is licensed under Chapter 397 Florida Statutes for substance abuse provided their facility operating procedure, which included a written plan for delivery of mental health and substance abuse services. According to the provided initial treatment plan for each youth, a new full comprehensive evaluation is completed, within thirty days of arrival, for each youth entering the program. The comprehensive assessment includes elements for both mental health and substance abuse. Furthermore, the mental health and substance abuse comprehensive evaluation includes demographic information, justification for the evaluation, reason for the assessment, behavioral observations, mental status examinations, methods of assessment, interviews or other procedures used to acquire the needed information, patterns of alcohol and drug usage, impact on major life areas, risk of continued usage, discussion of findings, diagnostic impressions including the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, recommendations, and relevant background information. Relevant background information includes home environment, family functioning, history of abuse to include physical and sexual, history of neglect, witnessing of violence and other forms of trauma, behavioral functioning, physical health, and educational functioning. A review of five youth records found documentation in all records included consent signed by each youth for substance abuse services. Three of the five reviewed records indicated new comprehensive evaluations were completed by a non-licensed clinical staff and in all five the comprehensive evaluations were reviewed and signed by a licensed qualified professional. The remaining two comprehensive evaluations were completed by a licensed qualified professional. All five comprehensive evaluations included all required elements for both mental health and substance abuse evaluations and addressed the original reason for the referral. A review of all five records found documentation in all records contained a Comprehensive Mental Health and Substance Abuse Evaluations which were completed within thirty days of each youth's arrival in the program.

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

The program has a policy and procedures addressing mental health and substance abuse treatment. The program assigns each youth admitted to the program with a multidisciplinary treatment team. The treatment team consists of the youth and representatives from program administration, the residential living unit, medical staff, vocational training staff, education and mental health staff, substance abuse staff, other staff responsible for delinquency intervention and treatment services, and when possible the youth's parent/guardian. All five youth records reviewed validate the treatment teams for each youth were made up of the above-mentioned disciplines. All five reviewed records contained properly executed Authority for Evaluation and Treatment (AET) forms and signed Substance Abuse Consent Forms and Release forms. In all five reviewed records, treatment was documented on forms which contain all the required elements. The program is licensed by the Department of Children and Families (DCF) to provide outpatient substance abuse treatment services under Chapter 397 of the Florida Statutes. The Chapter 397 expires on October 25, 2020. Services are provided by qualified licensed and non-licensed clinical staff and include daily group therapy, individual therapy every other week, and monthly family therapy. A review of five records document mental health groups contained ten or fewer youth and substance abuse groups contained fifteen or fewer youth. Each of the five interviewed staff reported direct care staff do not facilitate mental health or substance abuse groups. All five interviewed youth reported participating in groups and receiving specialized therapies. An interview with the designated mental health clinician authority confirmed the various treatment services provided and who facilitates the services.

3.07 Treatment and Discharge Planning (Critical)	Satisfactory Compliance
Youth determined to have a serious mental disorder or substance abuse impairment, and are receiving mental health or substance abuse treatment in a program, shall have an initial or individualized mental health or substance abuse treatment plan. When mental health or substance abuse treatment is initiated, an initial or individualized mental health or substance abuse treatment plan is completed. *All youth who receive mental health and/or substance abuse treatment while in a residential program shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.*	

The program has a policy and procedures addressing treatment and discharge planning. The process includes each youth receiving an initial treatment plan upon admission and an individualized treatment plan within thirty days of admission. A review of five youth mental health and substance abuse (MHSA) records found documentation each record contained an initial MHSA treatment plan completed on the date of admission and included all the required elements. These documentation requirements include the youth's demographic information, reason for MHSA treatment, initial diagnostic impression or presenting symptoms, current

Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses and symptoms, initial treatment methods, and initial treatment goals. All five MHSA initial treatment plans were signed by the clinician completing them and treatment team members who participated in creating the plan. Four of the five plans were prepared by a non-licensed clinical staff and were countersigned by the designated mental health clinician authority (DMHCA) within ten days of completion. The remaining plan was completed and signed by the DMHCA within ten days of completion. One of the five youth records found documentation for psychiatric needs to be included on the initial treatment plan. The remaining four youth did not have psychiatric needs. All five records contained an individualized treatment plan (ITP) completed within thirty days of each youth arriving at the program. In all five of the reviewed records, the ITP included all Department required information. This information included documentation of youth demographics, current DSM diagnoses and symptoms, mental health and/or substance abuse treatment goals, mental health and/or substance abuse treatment methods or interventions, psychiatric services, and strength and needs of both the youth and family. Three of the five youth's ITPs required psychiatric services to include the psychotropic medication and frequency of monitoring by psychiatrist. The remaining two youth were not applicable. In all five records, the ITP was signed by the mental health/substance abuse clinical staff completing the plan and all other treatment team members who participated in the development of the plan. Three of the five reviewed records indicated the ITPs were completed by a non-licensed clinical staff and in all five records the ITPs were reviewed and signed by a licensed qualified professional within ten days of completion. In all five reviewed records, documentation was found indicating each youth were receiving the services prescribed in their ITP. ITP reviews are completed every thirty days in order to document the youth's progress towards the goals and objectives on their ITP. All five treatment plan reviews contained the following required elements; documentation of a current DSM diagnosis and symptoms, mental health and/or substance abuse treatment goals with documentation of progress made by each youth in meeting each treatment goal, and any changes in mental health and/or substance abuse treatment methods or interventions, and psychiatric evaluations and recommendations. In the five records reviewed there were a total of twenty-eight treatment plan reviews. All twenty-eight treatment plan reviews were completed within the thirty-day requirement. A total of three closed youth records were reviewed. All reviewed records contained documentation of the discharge instructions from the discharge summary discussed at the exit staffing and signed by each youth and therapist. One of the three closed discharge summaries required notification of suicide risk to be made to the parent/guardian and the juvenile probation officer (JPO) for suicide alert/suicide precautions. Notifications to the parent were made by telephone and through mail, as well as to the JPO through email. Two of the three youth discharge plan summaries were not discussed with all required parties at the exit conference due to nonattendance by the parties. One of the three youth records reviewed indicated a copy of the discharge summary was mailed to the parent/guardian and one youth record indicated the JPO and the parent/guardian were unable to be reached for the exit conference, but letters were mailed to each. The remaining youth discharge plan was discussed with all parties during the exit conference.

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

The program has a policy and procedures addressing specialized treatment services. The program is licensed under Chapter 397 and offers specialized treatment services in the form of Substance Abuse Treatment Overlay Services (SAOS). As a part of these services, the program

provides group therapy seven days a week, each youth receives individual therapy at a minimum of once every other week and family therapy sessions at a minimum of one time a month. Therapeutic activities are provided seven days a week. The program contracts with a licensed psychiatrist who provides on-site psychiatric services every other week. There are two full-time non-licensed therapists employed at this program. The designated mental health clinician authority (DMHCA) is on-site Monday through Friday weekly for a minimum of forty hours a week and is on-site on weekends as needed. The therapist caseload is fourteen which is under the required caseload size. The facility has a psychiatrist available to provide additional services as needed. Youth with co-occurring substance abuse and mental health disorders receive both substance abuse and mental health treatment by qualified personnel. Based on the reviewed records, mental health groups were limited to no more than ten youth and substance abuse was limited to no more than fifteen youth. An interview with the DHMCA confirmed the various specialized treatment services the program provides.

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 contracts with a licensed psychiatrist for the provision of psychiatric services to youth in the program. These services include an initial psychiatric evaluation, within fourteen days, for all youth entering the program, participation in treatment planning, and supervision of the treatment for youth who are prescribed medications in collaboration with the designated mental health clinician authority (DMHCA) and members of the treatment team. The initial psychiatric interview is documented on the Clinical Psychotropic Progress Note (CPPN) and includes a mental status exam, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, treatment recommendations and the youth's history related to medical, mental health, and substance abuse. When the youth is admitted to the facility on psychotropic medications or is prescribed them following the initial psychiatric evaluation, the CPPN will also include the prescribed medication, the frequency of medication monitoring and management, an explanation and justification for the medication as it relates to the youth's diagnosis, target symptoms, initial treatment goals, and any applicable side effects, risks and benefits of taking the medication. A review of five records found documentation indicating one of the five youth arrived at the program on psychotropic medication and the record contained an Initial Diagnostic Psychiatric Interview which included all necessary elements. The remaining four records also included an Initial Diagnostic Psychiatric Interview, which contained all necessary elements for youth not prescribed psychotropic medication. At the time of the review, one youth from the original five record sample was admitted to the program on psychotropic medication. The program provided two additional records for youth who entered the program on psychotropic medication for review. The initial psychiatric interview is documented on the CPPN and includes a mental status exam, DSM diagnosis, treatment recommendations and the youth's history related to medical, mental health, and substance abuse. One youth was placed on psychotropic medication within the first thirty days of admission to the program. When the youth is admitted to the facility on psychotropic medications or is prescribed them following the initial psychiatric evaluation, the CPPN will also include the prescribed medication, the frequency of medication monitoring and management, an explanation and justification for the medication as it relates to the youth's diagnosis, target symptoms, initial treatment goals, and any applicable side effects,

risks and benefits of taking the medication. The four records also indicate each youth received follow-up and medication management services from the psychiatrist at least once every thirty days. An interview conducted with the contracted psychiatrist confirms he is on-site biweekly Friday through Monday with Sunday being the typical day on-site for a minimum of two hours per visit to provide services and the psychiatrist is available twenty-four hours a day, and seven days a week for emergency consultation.

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

The program has a suicide prevention plan in place to address the prevention of suicide which received an annual review by the executive director and the designated mental health clinician authority on January 15, 2020. The plan included procedures for identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process.

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

All youth were referred for an Assessment of Suicide Risk (ASR) as part of the program's standard intake process and the assessments included all required elements and was completed by non-licensed clinical staff under the supervision of a licensed mental health professional and included a review and signature of the designated mental health clinician authority (DMHCA). Documentation was provided which indicated the staff who conducted the ASR received the required twenty hours of training provided by a licensed mental health professional which included the completion of five co-assessments. Following the completion of the ASRs, four of the five youth were placed on standard program supervision and one was authorized to be placed on precautionary observation at a level of constant supervision. An alert was placed in the Department's Juvenile Justice Information System and there was documentation to indicate the youth's parent/guardian and juvenile probation officer were notified of the change in the youth's supervision level. The ASR findings were documented in the facility logbook. There was documentation of a supportive session provided by the mental health staff to the youth after being placed on precautionary observation. The youth was stepped down to close supervision as the result of the follow-up ASR and a conference between the executive director and DMHCA. Following the completion of a mental status exam and consultation between mental health staff and the executive director, the youth was placed on standard program supervision. During the time the youth was maintained on constant supervision, he was able to participate in select activities and the safe housing areas were

clearly identified. There were no other youth placed on precautionary observation during the review period. During interviews with five staff, it was reported when a youth expresses suicidal thoughts, they are responsible to notify mental health and administration, place youth on constant sight and sound, document supervision, and search youth. The staff reported the suicide response kits are located in master control and medical.

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

The program has a policy and procedures addressing suicide prevention services. One of the five reviewed youth records contained suicide precaution observation logs for a youth who was on constant supervision during the annual compliance review period. All observation logs were maintained the entire time the youth was on precautionary observation with one exception of one thirty-minute check was missed. The program never responded to this exception, therefore, the exception remains. The observation logs indicated the youth was maintained at the appropriate level of supervision and identified the safe housing areas. There were no warning signs documented in the observation logs. The observation logs all indicated they were reviewed by each shift supervisor and mental health clinical staff and were signed by the respective disciplines in the appropriate location. There was only one youth placed on precautionary observation during the annual compliance review period.

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

The program has a policy and procedures addressing suicide prevention training. A review of five pre-service and five in-service staff records indicated all completed the requisite six hours of annual suicide prevention training which included two hours of training documented in the Department's Learning Management System (SkillPro). A review of mock suicide drills and sign-in sheets revealed drills were conducted on each quarter for all shifts by the designated mental health clinician authority (DMHCA). Sign-in sheets for the drills supported staff participated in the required amount of drills during the last year. An interview with the DHMCA and executive director indicated the program provides training or mock drills for staff, which includes emergency response to suicide attempts or self-inflicted injury.

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 crisis intervention plan separate from the emergency mental health and substance abuse services plan in place which received an annual review by the executive

director and designated mental health clinician authority on January 15, 2020. The plan included notification, an alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The plan included the use of the Department's Crisis Assessment form.

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

The program has a policy and procedures addressing crisis intervention services. Procedures include staff should utilize the Department's Crisis Assessment form when engaged in a crisis intervention. One of the five youth were applicable for crisis assessment; therefore, the program provided the only one additional applicable youth record. In the two instances, each youth were seen within two hours of being determined to be in crisis. The provided assessments included the reason for the assessment, a mental status exam and interview, the determination of danger to self and/or others, clinical impressions, recommendations for supervision, treatment, and follow-up or further evaluation. In one of the two instances, the youth's parent/guardian were notified by mail of the assessment and the results while the other youth's parent/guardian received verbal notification of the assessment and the results. Both crisis assessments provided were completed by the designated mental health clinician authority.

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

The program has an emergency mental health and substance abuse services plan separate from the crisis intervention plan in place which received an annual compliance review by and signed by the executive director and designated mental health clinician authority on January 15, 2020. The plan included immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services including Baker Act and Marchman Act, documentation, training (including mock drills), and review.

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

The program has a policy and procedures regarding the Baker and Marchman Acts. Since the last annual compliance review, the program has not had any youth referred for a Marchman Act; however, one youth was referred for a Baker Act. The youth referred for the Baker Act was not referred due to suicidal ideation or self-harm. The youth was Baker Acted due to hearing auditory hallucinations during a therapy session. The non-licensed mental health clinician notified the designated mental health clinician authority (DMHCA) decided to have the youth removed from the facility by the police department and transported to the Baker Act facility. The licensed mental health staff completed the Assessment of Suicide Risk (ASR) within two hours. The youth was on placed on one-to-one supervision upon determination youth was in need of a Baker Act. The mental status examination was conducted by the licensed mental health counselor. The youth was placed on constant supervision upon return to the program from Baker Act. The licensed clinical staff and the facility administrator conferred with each other prior to youth being stepped down from close supervision to standard supervision. The JJIS alert was entered when the youth returned to the facility from the Baker Act; however, the alert was not closed when the youth was stepped down to standard supervision. The program fixed this mistake when it was brought to the program's attention.

Standard 4: Health Services

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

The program has a contract with a licensed physician, who acts as the program's designated health authority (DHA), and they are responsible for providing oversight and supervision of all health and medical services, including general supervision of all medical personnel. The DHA is responsible for the overall clinical direction, policies, and protocols for medical services at the program. A review of the Department of Health Medical Quality Assurance License search website revealed the DHA's license is clear and active in the state of Florida and expires on January 31, 2021. The DHA is scheduled to be on-site weekly, and is on call twenty-four hours a day, seven days a week. A review of the medical sign-in/out-logs for the last six months confirmed the DHA was on-site weekly. The DHA uses the services of two other licensed physicians, as a back-up when they are unable to provide services to the youth at the program. A review of the medical sign-in/out-logs indicated one of the back-up physicians was on-site during the one week the DHA was not. A review of the Department of Health Medical Quality Assurance License search website revealed one of the back-up physician's license is clear and active in the state of Florida and expires on January 31, 2021. The second back-up physician's license was also reviewed, and it is also clear and active in the state of Florida and expires on January 31, 2020. A review of seven youth Individual Healthcare Records (IHCR) indicated the DHA conducts sick calls when they are on-site, as well as, provides routine medical care, and periodic evaluations for youth with chronic conditions. The DHA provides all follow-up medical care when a youth is referred by nursing staff. An interview with the DHA indicated they are on-site weekly to evaluate new youth, chronic conditions, episodic care, and assist with sick calls. The DHA further indicated they review lab and radiology information and participated in the development of the program's medical policy and procedures. The DHA also indicated they participate in meetings with medical staff and other program departments. The DHA further indicated they ensure the health of the youth at the program and everything related to their care. The DHA confirmed they have one doctor available for coverage and an additional doctor for backup coverage for vacation and scheduled absences, when necessary. During the interview the DHA indicated they have no concerns about the health care being provided at the program since they communicate with the medical and program staff as necessary to address any concerns.

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 has facility operating procedures (FOP) for all health-related procedures and protocols used at the program. A review of documentation indicated both the executive director (ED) and the designated health authority (DHA) conducted an annual review and signed off on the FOPs and protocols on January 15, 2020. A review of the psychiatric FOPs indicated the program's psychiatrist conducted an annual review of their respective protocols on August 2, 2019. As part of the program's nursing pre-service training plan all new medical staff are required to review the medical FOPs and protocols and sign the cover sheet indicating they have reviewed them. Two full time nurses and one pro-re-nata (PRN) nurse who works at the

program signed an FOP cover letter acknowledging they have read and understood all nursing FOPs and healthcare protocols.

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 has a policy and procedures in place to ensure parents, and/or legal guardians are afforded the right to give or withhold consent with regards to the healthcare provided to their children while they are in the program. Five youth Individual Healthcare Records (IHCR) confirmed none of the youth had an original Authorization for Evaluation and Treatment (AET). All five reviewed records contained a signed AET, with the word 'copy' stamped or printed on the AET. An interview with the program's registered nurse (RN) indicated the Department's juvenile probation officer (JPO) is responsible for ensuring the AET is signed and dated by the parent/guardian at the first available opportunity. The RN also indicated when a youth is eighteen years of age the youth completes a release of information authorization form for youth eighteen years and older.

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 has a policy and procedures in place to address parental notification and consent for treatment. Seven youth Individual Healthcare Records (IHCR) were reviewed for parental notifications and consent for treatment. Four of the five records confirmed the presence of the required parental notification and the fifth record did not require parental notifications since the youth turned eighteen years old at the time of admission, and only consented to their parent/guardian receiving emergency medical information. A review of the four applicable records revealed two records required the youth's parent(s)/guardian(s) to receive parental notification for over-the-counter (OTC) medications beyond those covered by the Authorization for Evaluation and Treatment (AET). None of the records were applicable for notification of a vaccination not consented for on the AET. Four of the five records were applicable for notification when significant changes to existing medications occurred. None of the records were applicable for discontinuation of medication prescribed prior to the youth entering the Department's custody. One of the records was applicable for changes in condition/medication for youth with chronic conditions. Two records were applicable for parental notification for invasive dental procedures. Three youth were taken off-site for medical treatment, and their records contained notification to the parent/guardian when these events occurred. None of the records were applicable for off-site emergency notifications. Four applicable records contained documentation in the nursing progress notes verbal attempts, and parental consent was received for all new medications. All applicable records contained written notifications regardless if verbal consent was received. All applicable records contained documentation a second staff member witnessed all telephone call attempts and conversations regarding parental consent. Three youth were applicable for written consent for the administration of psychiatric medications and all contained written notification with an attached Clinical Psychotropic Progress Note (CPPN), which was sent to the youth's parent/guardian. One youth was in the care of the Department of Children and Families (DCF) where there had been a termination of parental rights, and the record contained a court order authorizing all treatment, medications, and procedures. The registered nurse (RN) was interviewed and indicated parental

notifications are made verbally and then a written document is sent out as soon as an order is given, or an event has occurred. The RN indicated parental notifications are required for all emergencies, off-site appointments, hospitalizations, and for new, revised, or discontinued medications. The RN also indicated each parent/guardian is verbally contacted for consent prior to starting psychotropic medications, and if the parent/guardian cannot be reached verbally they are sent a consent form along with page three of the CPPN. The program has a policy and procedures in place to ensure a youths' immunization history is obtained and all youth have received proper immunizations. The program obtains the youth's immunization records from the youth's electronic commitment packet and from the electronic Florida Shots database. A review of five youth IHCR contained immunization and vaccination records and they were reviewed by a program nurse within thirty days of each youths' admission. None of the reviewed records contained a refusal for consent of immunizations for religious reasons. An interview with the program's RN indicated the youth's parent/guardian should provide the program with a copy of the exception form from the county health department and the form will be filed in the youth's IHCR.

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 has a policy and procedures in place for the completion of the Facility Entry Physical Health Screening (FEPHS) form for all youth on the date of their admission. A review of five youth Individual Healthcare Records (IHCR) contained a FEPHS completed on the date of the youth's admission. All reviewed FEPHS were completed by a registered nurse (RN). None of the reviewed records indicated the youth had a change in their physical custody since their admission. An interview with the registered nurse (RN) indicated all new admissions are seen by the medical department, for a medical evaluation, immediately. The RN confirmed the FEPHS form is completed by a registered nurse. The RN also indicated upon re-admission to the facility the youth is brought to medical first and a new FEPHS and body chart is completed.

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 has a policy and procedures in place indicating all youth will receive orientation to the program's healthcare services on the day of their admission. A review of five youth Individual Healthcare Records (IHCR) contained documentation the youth received healthcare orientation the same day they were admitted to the program. The program documents each youth's orientation to healthcare services on a program form entitled, Youth Health Education Summary. There was documentation in all reviewed records the youth were oriented to the sick call process, access to medical care, what constitutes an emergency, the medication process and side effect monitoring, the right to refuse care and how to document it, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care staff. Each youth's orientation form indicated they were advised of who the designated health authority (DHA) was, as well as the name of the program's psychiatrist. The program had a list of healthcare staff contacts located on a bulletin board in the medical clinic and the list was in an area where the youth could not view it. A review of the list had the correct DHA, nursing staff and psychiatrist listed. All five reviewed IHCRs contained a completed health education

record form indicating all the topic's each youth had or will receive education on while at the program. Topic's the youth will receive education on are personal and dental hygiene, bloodborne pathogens exposure and control, alcohol/substance abuse, sexually transmitted diseases, smoking cessation, prevention of communicable diseases, cardiovascular health, physical fitness, human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) general information, nutrition basics, breast self-exam, testicular self-exam, family planning, prevention of accidents, what to do in the case of sexual assault or attempted sexual assault, right to refuse care, and the non-disciplinary role of the healthcare provider.

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 has a policy and procedures in place indicating after the healthcare staff reviews the youth's record and completes the screening and/or reviews the completed screenings, they are to notify the designated health authority (DHA) telephonically or verbally for all newly admitted youth regardless of any identified medical conditions. The purpose of the notification is to provide a comprehensive overview of the youth's medical conditions to the DHA and to obtain initial admission orders, initial medication orders, preliminary laboratory studies, diet orders, activity release or restrictions, and any other specific treatment orders or instructions for the youth with a health-related condition. A review of five youth Individual Healthcare Records (IHCR) revealed the DHA was notified of each youth's admission to the program and their medical history was shared with the doctor. There was documentation in all records of the date and time the DHA was notified. All records contained a nursing progress note indicating the DHA was notified by telephone of the youth's admission. In one of the five records, the DHA was notified of the youth's chronic condition. None of the reviewed records reflected the youth needed emergency services upon their admission. Documentation in all IHCRs indicated each youth was referred to the doctor for their Comprehensive Physical Assessment. An interview with the registered nurse (RN) indicated the nursing staff notify the DHA of each youth's admission with a chronic condition and the youth are referred to the DHA, which is captured on the admission nursing progress note.

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 has a policy and procedures in place indicating a Health-Related History (HRH) form will be completed within seven days of a youth's admission. A review of five youth Individual Healthcare Records (IHCR) revealed the program completed a new HRH form on all youth the day they were admitted to the program. All HRH forms were completed by a registered nurse. All HRH forms were reviewed by the designated health authority (DHA) and all were completed prior to the Comprehensive Physical Assessment (CPA). An interview with the registered nurse (RN) confirmed all HRH forms are completed by a registered nurse upon the youth's admission.

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

The program has a policy and procedures in place to ensure each youth receives a physical health evaluation after their admission. A review of five youth Individual Healthcare Records (IHCR) revealed each youth had a Comprehensive Physical Assessment (CPA) completed by the designated health authority (DHA) within seven days of their admission. Each CPA contained the youth's medical grade issued at admission and were completed in accordance with the Department's Rule. All five records contained documentation the youth refused the examination of anus and rectum, under their right to refuse and the female portion of each examination was not applicable to the reviewed records. Each youth's problem list accurately reflected each youth's medical conditions. An interview with the registered nurse (RN) indicated the DHA completes an initial CPA at admission and annually thereafter. The program has a policy and procedures in place to ensure youth receive routine healthcare screenings and evaluations upon admission to the program for latent or active tuberculosis, as well as environmental controls for the program. The program's policy follows the Centers for Disease Control and Prevention, as well as the Occupational Safety and Health Standards. A review of five IHCR revealed each record contained a current verified tuberculin skin test (TST) test. The tier 1 tuberculin (TB) screening portion of the FEPHS form was completed and found in all records. All records had the TST results documented on the Infection and Communicable Disease (ICD) form, as well as the Comprehensive Physical Assessment (CPA) form. Two of the five reviewed records required the youth to have an updated TST test while the youth was in the program, and the youth's IHCR reflected the youth received a new TST test. An interview with the registered nurse (RN) confirmed all youth are screened for TB upon admission and re-entry using the Facility Entry Physical Health Screening form. The RN indicated all youth are given a TST test annually.

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 has a policy and procedures in place to ensure youth receive sexually transmitted disease/infection screening, evaluations, and testing. A review of five youth Individual Healthcare Records (IHCR) revealed all youth were screened by nursing staff upon their admission for sexually transmitted infections (STI); however, the designated health authority (DHA) did not ordered STI testing for any of the youth based on their answers to the STI screening. None of the reviewed records were youth who were out of the Department's custody for more than thirty days and did not require a re-screening for STIs. An interview with the registered nurse (RN) indicated all youth are screened for STIs upon admission and if the screening indicates a need for further evaluation the youth is referred to the DHA. The RN indicated all STI screenings, evaluations, referrals, and testing documents are maintained on the STI screening log. The program has a policy and procedures in place to ensure all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, and referred for medical treatment. The program uses Help Us Help U, Inc. to conduct their pre- and post-HIV testing. The program's practice is to have an individual certified by the Florida Department of Health-Division of Disease Control and Health Protection from Help Us Help U, Inc. comes to the program to conduct HIV prevention counseling, testing, and linkage to services. The program was able to supply the review team with the Help Us Help U, Inc.

500/501 HIV/AIDS certification by the Florida Department of Health, which was updated in June 26, 2019. A review of five youth IHCR revealed all youth were offered HIV testing, counseling, and received general education about the disease. Three of five youth records revealed each youth consented to HIV testing. The three applicable records revealed each youth consented to HIV testing. Each youths' health education records revealed they received pre- and post-testing counseling from a Help Us Help U, Inc. certified HIV counselor. All three of the applicable reviewed records contained a sealed envelope, which contained the youth's HIV testing results, and the envelope was marked confidential. The two remaining youth refused HIV testing. A review of the program's internal medical alerts and the Department's Juvenile Justice Information System (JJIS) alerts revealed there were no alerts related to a youth's HIV status. An interview with the registered nurse (RN) confirmed all youth are offered an HIV test upon admission and the HIV consent form is completed indicating their consent or refusal. The RN also indicated the HIV consent form is maintained in each youth's IHCR. The RN confirmed the program uses the Help Us Help U, Inc. program to perform all HIV pre-counseling, testing, and post-counseling. The RN indicated HIV testing is documented on the youth's Health Education Record form. Five interviewed youth indicated they could request an HIV test if they wanted one.

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 has a policy and procedures in place to ensure there is a system in place to respond to the complaints of youth illness or injury of a non-emergent nature. The policy indicates sick call care, including dental complaints shall be available to all youth. Sick call care shall be provided by licensed health care professionals, pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). The program has postings of the sick call hours in the day room, and on the medical examination clinic door. The program also has Sick Call forms available in the day room along with a locked sick call box, which is checked several times a day by nursing staff. The program completes sick call two times a day, seven days a week and nursing staff is on-site daily for twelve hours. Sick call is always conducted by a registered nurse (RN). Sick call is conducted Monday through Sunday 9:30 a.m. and 2:00 p.m. A review of five youth Individual Healthcare Records (IHCR) revealed four youth submitted one Sick Call Request each. There was a total of four Sick Call Requests reviewed. None of the four reviewed records presented with similar sick call complaints three or more times within a two-week period. All Sick Call Request forms were filed in the progress note section of each youth's IHCR in reverse chronological order. There were no sick call complaints of any severe pain with which nursing staff were unfamiliar. All Sick Call forms were documented in accordance with the Department's Rule and contained the youth's vital signs, treatment, education, and any follow-up plans. All sick calls were documented on the youths' Sick Call Index in their IHCR and on the program's Sick Call Referral log. During the annual compliance review, no Sick Call Requests were submitted. Therefore, no sick calls were able to be observed. Five youth were interviewed, and all indicated they could see the nurse within two hours of putting in a sick call or sometimes they could see the nurse immediately. Five staff were interviewed and they all indicated nursing staff responds to sick calls. The five staff indicated if a youth requests to see the doctor the youth can be placed on the doctors list and they will be seen by the doctor. An interview with the registered nurse (RN) confirmed sick call is

conducted two times a day, seven days a week at the times listed above. The RN further indicated if the youth is to be referred to the doctor for further assessment they are placed on the doctors medical list and are seen when the doctor is on-site. The RN confirmed the DHA has approved all treatment protocols and the signed protocols were provided to the review team.

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 has written policy and procedures for the provision of emergency medical care, including emergency dental treatment. The DHA is available by telephone twenty-four hours a day, seven days a week for consultation. Postings were found throughout the program informing staff of their right and responsibility to call 9-1-1. The program has a comprehensive process for the provision of episodic, and first aid care. The program has a registered nurse (RN) on-site twelve hours a day, seven days a week; during the review period, there was no evidence of non-healthcare staff providing first aid/or episodic care to the youth. A review of five youth Individual Healthcare Records (IHCR) confirmed four records were applicable for episodic care, first aid, and emergency care. There were six instances of episodic care reviewed in the four applicable records. Nursing staff documented each event in the nursing chronological progress notes and label it, as an episodic event. Each episodic incident was documented in problem-oriented narrative charting indicating the subjective, objective, assessment, and plan (SOAP format). All six instances of episodic care were listed on the program's episodic care log. One of the episodic incidents resulted in the youth being place on medical and internal alerts. The youth was referred to off-site care for follow-up on the youth's care. A review of five non-healthcare staff training records contained documentation of current first aid, Epinephrine Auto-Injector, basic cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) certifications. The two full-time nurses and one part-time nurse all had current first aid, CPR, and AED certifications. The program had listings of emergency telephone numbers to include the Poison Control Center number in the medical clinic; and they were inaccessible to the youth. Interviews with five staff indicated they all knew they could call 9-1-1 regarding a medical emergency. All staff indicated they would take the youth to medical and medical would call 9-1-1 or they would have to contact master control and have them call 9-1-1. Five interviewed youth indicated they could see a dentist if they had tooth pain and could see the doctor instead of the nurse if needed. The program has a total of seven first aid kits and they are in master control, medical, kitchen, classroom, maintenance, and one in each of the two vans used for transportation. The program has two suicide response kits and they are in master control and medical. Documentation reviewed supported the nursing staff conduct weekly reviews of the first aid kits and monthly checks of the suicide response kits. During the annual compliance review, three first aid kits were opened and inventoried. Two of the first aid kits inventoried were used for transports and one was maintained in medical. All the first aid kits contained all items approved by the DHA to be in the first aid kits and were within expiration dates. The program has one AED and it is maintained in master control. The AED battery expires March 13, 2021 and were last changed on March 13, 2017. The pads expire in August 2020 and were last changed on July 29, 2018. The AED instructions were found attached to the AED and the registered nurse (RN) stated the instructions are also located within medical. Reviewed documentation confirmed the nursing staff conducted monthly testing of the AED for the entire review period. The program is required to conduct monthly medical drills on all three shifts with CPR/AED being practiced at least quarterly. A review of the medical drill documentation for the last year indicated drills were conducted monthly. The medical drills further indicated the

program staff demonstrated CPR and the use of the AED at least quarterly on each shift while conducting the medical drills. An interview with the RN indicated the program documents all episodic care conducted by the doctor or the nurse in the nursing progress notes. The RN indicated if a non-healthcare staff provided first aid/emergency care they would document the incident on the Report of On-Site Health Care by Non-Health Care Staff form. The form would then be reviewed by an RN the following morning and the incident would be placed on the program's episodic care log. The form would then be filed in the youth's IHCR. The RN also indicated they track all off-site appointments on the program's monthly tracking log and off-site appointment calendar.

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 has a policy and procedures in place outlining the program's procedures for off-site care and referrals. Five youth Individual Healthcare Records (IHCR) were reviewed and one was applicable for off-site care visits. The one applicable record was applicable for parental notification and the parental notification was maintained in the youth's IHCR. There was a total of one off-site care instances in the one applicable record. The one applicable record had the Departments' Off-site Care form used and the form was filed in the youth's IHCR. The applicable record had the Off-site Care form reviewed and signed by the designated health authority (DHA). The applicable record had the required follow-up testing, referral, or appointment and there was documentation in the record the youth received the necessary follow-up care or appointment was scheduled. An interview with the registered nurse (RN) indicated the program tracks all off-site youth appointments by placing the appointments on the program's off-site appointment calendar, medical tracking log and the episodic care log. The RN indicated once they receive the off-site care findings, the RN will notify the DHA of any orders or instructions. Then the off-site summaries with all attachments will be flagged in the youth's IHCR to ensure all off-site forms are reviewed and signed by the DHA during their next visit to the program. An interview with the DHA confirmed the process described by the RN as the program's process to ensure off-site forms are reviewed by them.

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 has a policy and procedures in place for youth with chronic medical condition(s), which indicates youth shall have treatment plans/physical progress notes which specify a youth's course of therapy, identifies the role of qualified health professionals in carrying it out, and is updated as needed. The policy further indicates youth with a chronic condition, communicable disease, receiving prescription medications including psychotropic medications, or are being treated for tuberculosis shall receive a periodic evaluation from the physician at least every ninety days. This is tracked in the medical tracker and computer. A review of five youth Individual Healthcare Records (IHCR) revealed one youth had a chronic medical condition identified at admission and required placement on the program's chronic condition list. Two more of the five reviewed records revealed the youth was on the chronic conditions list due to being on psychotropic medications; thus, a total of three youth records were reviewed for chronic conditions and periodic evaluations. A review of the program's chronic condition list

revealed all three applicable youth were appropriately placed on the list and their corresponding medical conditions and/or medication regiment was properly listed. The one youth identified with a chronic medical condition was also identified as being on psychotropic medications. This youth was seen by the designated health authority (DHA) every ninety days for a medical periodic evaluation and by the psychiatrist monthly for medication monitoring. The other two records were youth who were placed on the chronic conditions list due to being on psychotropic medications and they received monthly medication monitoring by the psychiatrist. All documentation for the periodic evaluations and medication monitoring evaluations were found in each youth's IHCR. All applicable youth records contained specialized treatment plans for the youth based on their chronic conditions. None of the youth were applicable for anti-tuberculosis medications. All treatment orders were written clearly and were distinguishable for clinical staff to interpret. None of the periodic evaluations were conducted off-site. A review of all applicable records revealed there were no lapses in care or missing periodic evaluations. A review of five youth IHCRs revealed all youth's problem list accurately reflected each youth's physical health, dental health, and mental health. An interview with the DHA confirmed youth with chronic conditions are evaluated at least every ninety days unless otherwise specified. The DHA indicated the nursing staff keep track of chronic conditions with a tracker and the nurse put the youth on their clinic list when they are due for their periodic evaluations. An interview with the registered nurse (RN) indicated youth admitted with a chronic condition are evaluated by the DHA during the initial physical and are placed on the program's chronic condition list and seen at least every ninety days after the initial physical. Additionally, the RN indicated a youth who develops a chronic condition after admission will be seen at least ninety days after the diagnosis by the DHA.

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 has a policy and procedures in place to ensure youth receive all prescription medication(s) as prescribed by a physician. The policy indicates medical staff shall verify any medications arriving with a newly admitted youth. The program's policy also indicates only medications from a licensed pharmacy, with a current, patient-specific label intact on the original medication container may be accepted into the program. The policy further indicated verification of the actual medication contents is not required if the youth has been transferred directly from the Department and the medications have been under the Department's control the entire time. A review of five youth Individual Healthcare Records (IHCR) revealed two youth entered the program with currently prescribed medication. Therefore, reviewer requested an additional record to review, to meet the three record review minimum requirement. The three applicable youth who entered the program with medications entered the program from a Department detention center and verification was noted on the Department form entitled, Medication Receipt, Transfer, and Disposition. Each youth's nursing progress note indicated staff verified the youth's medication with the parent/guardian upon the youth's admission. All applicable records reflected the designated health authority (DHA) was notified when the youth entered the program with prescribed medications. All youth records reflected the DHA advised the program to continue all medications until the youth were seen in person for their initial medical evaluation. All three youth entered the program with psychotropic medications, and the program's assigned psychiatrist was also notified of the youth's admission and the psychotropic medications they were taking. Each youth's nursing progress note indicated the psychiatrist continued all medications until the youth were seen in person for their initial psychiatric

evaluation. An interview with the registered nurse (RN) indicated the program nursing staff verifies medication upon the youth's admission from the Medication Administration Record (MAR) and medication transfer sheet, which is transferred with the youth from a Department program. The RN further indicated if the youth is admitted from home with medication, the pharmacy would be called to verify the medication. The RN also indicated non-healthcare staff do not verify medications at the program. Two of the five reviewed records reflected the youth received over-the-counter (OTC) medications not listed on the AET form and they were administered in accordance with the approved nursing protocols. None of the youth's parents/guardians prohibited the administration of OTC medications. All five reviewed youth IHCRs contained one or more MAR form. Three of the five records were youth who arrived at the program on medication and all applicable records contained an initial MAR which matched the medication the youth was receiving upon their arrival. All MAR forms contained the youth's name, Department identification number, date of birth, allergies, precautions, medical grade, side effects, and medical alerts. A photograph of each youth is maintained in the current medication administration book, along with the current months MAR. Each MAR indicated the youth received medication as ordered and the MARs clearly indicated when medication started and stopped. Each time a medication was administered the staff initialed the medication entry. A review of the MARs indicated nursing staff documented weekly side effect monitoring for all medications administered. There were no lapses or errors in medication administration in the any of the reviewed youth records. All refusals are marked with the letter 'R' on the MARs and had a corresponding signed refusal form in the nursing progress notes. There were no youth who refused their medications. An interview with the RN indicated the program uses pre-printed pharmacy MARs provided by their contracted pharmacy, First Choice Pharmacy. Observations of the medication administration office indicated the office was neat, clean, organized, and contained an locked entry. The medical cart where all medications were stored was neat, clean, organized, and locked. The program stores oral medication separately from injectable and topical medications. The program stores narcotics and other controlled medications is a lockable drawer within the locked medical cart. All other medications are stored in the medication cart, which is secured, locked, and inaccessible to the youth. The program maintains all stock medications in a locked cabinet in the medical clinic. The program has a process in place for the destruction of expired and/or discontinued medications. Unused non-controlled medications which are within the expiration date are returned to First Choice Pharmacy by giving the medications to the pharmacy consultant who comes to the program monthly and the program is given credit for the unused medications. A review of documentation confirmed the program returned medications to the pharmacy. If the unused non-controlled medications are expired the program destroys the medications by using a medication jar called Drug Buster. Two nurses verify the medication and then places the unused medication in the Drug Buster jar and when the jar is filled it is disposed of in the trash. All unused controlled medications are destroyed with the pharmacist and two nurses using the Drug Buster. The destruction of all medications is documented on the program's disposal of medication logs. A review of the logs indicated all medications were destroyed in compliance with the program's policy and procedures. The reviewer was able to observe an 8:00 a.m. medication pass. Each youth was brought to the day room by direct care staff. The registered nurse (RN) pushed the locked medication cart to the day room and locked it in place. When each youth came up to the medication cart the nurse verified the youth's name, medication, route, dosage, and time. The nurse asked each youth about their allergies and side effects of the medications they were receiving. After each youth took the medication, a visual mouth check was conducted by RN to confirm youth swallowed medication. An interview with five staff indicated the youth receive their medications from the nursing staff or a trained supervisory staff. Five youth were interviewed, and three youth indicated they do not take medications and do not know the process for receiving medication. The remaining two interviewed youth indicated they receive their

medications from nursing staff and were able to articulate the program's process for medication administration. An interview with the RN indicated the program does have non-healthcare staff trained to assist youth with self-administration of OTC medications. A review of documentation supports the program has four supervisory staff trained by a registered nurse to aid youth in self-administration of medication; however, only two of those staff have access to controlled medications and have been trained to aid youth with self-administration of controlled medications.

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 has a policy and procedures in place for the storage of medications and sharps. The program's policy indicates the program shall ensure all chemical products, drug and medicines, and medical, dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. Observations of medications indicated they were stored within the program's medical clinic. The youth's medications and over-the-counter (OTC) medications are in a locked medical cart maintained in the clinic. When observed the cart was locked and has separate storage areas for different forms of medications. The cart has an area where youth's medications are stored and has an additional lockable drawer, with a different key, which is used for controlled substances. The program maintains stock medication in locked cabinets in the medical clinic. The program contracts with First Choice Pharmacy, who is responsible for filling medication requests. The program has a contract with a pharmacist consultant who comes on-site monthly to retrieve medications for return, consultation and to aid in the destruction of medications. An interview with the registered nurse (RN) indicated all medications are inventoried daily with a perpetual count. The program conducts weekly counts of medications and the RN confirmed medications are stored within the medical clinic in locked cabinets and/or in the locked medical cart. The RN confirmed class two medications are destroyed on-site with the pharmacist consultant, and two nurses and all other medications are returned to the pharmacy. During the interview the RN confirmed all controlled medications are stored in a secure storage box within the secure medication cart. Observations confirmed all medications and sharps were securely stored in locked cabinets in the medical clinic. Syringes and sharps were counted using a perpetual inventory. The inventories are verified on a weekly basis, and the reviewer was able to observe the weekly counts were conducted by the RN and a shift supervisor witnessing. Opened OTC medications were inventoried using a perpetual inventory and verified weekly, and the reviewer was provided with documentation to support the nursing staff conducted the weekly counts for the entire review period. The program conducts shift-to-shift counts of controlled medications. The program maintains all controlled medication counts within the youth's Individual Healthcare Record or in the current monthly medication administration record binder. The program has a policy and procedures for detecting and responding to inventory discrepancies and the RN indicated in their interview if a discrepancy was found they would start with a recount of the medication. They further indicated if the medication was still off they would check with staff to see if they had taken any medication without logging it, and follow-up with the nurse who did the last medication pass to ensure there were no refusals of medication which were marked wrong. If the medication was still off, the nursing staff would report it to the executive director and the Central Communications Center. A review of the Department's Medication Administration Records (MAR) and documentation confirm the program maintained perpetual daily inventories for all prescription medications.

During the annual compliance review, an inventory of three sharps, three controlled medications, three youth medications and three OTC medications were conducted, and all were found to be accurate.

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

The program has an exposure control plan, as well as a policy and procedures in place for the control of infectious and communicable diseases. A review of documentation indicated both the executive director (ED) and the designated health authority (DHA) conducted an annual review of the plan and policy on January 15, 2020. An interview with the executive director (ED) indicated the exposure control and infection control plan is located within medical and the registered nurse conducts training with staff upon hire and yearly thereafter. The programs' infection control procedures included prevention, containment, treatment, and reporting requirements, as required by the Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control and Prevention (CDC) guidelines. The infection control procedures addressed all required types and categories of diseases outlined in the Department's Rule. There were no instances in which the local county health department, CDC, or the Central Communications Center required notification of an infectious disease. The programs' exposure control plan includes risk assessment and methods of compliance and contains all requirements of the Occupational Safety and Health Administration (OSHA) federal regulations. The policy included a comprehensive process for needle stick post-exposure evaluations. The program has not had any youth or employees who have experienced a facility/occupational exposure during the review period. There were no instances involving quarantining or hospitalization of at least ten percent of the program's total population or staff during the review period. A review of five staff training records indicated all staff received annual training in infection control and site-specific exposure control plan. All staff are offered Hepatitis B immunizations at the cost of the program. Five reviewed youth Individual Healthcare Records contained evidence of training in infection control, hand washing techniques, universal precautions, prevention of communicable diseases, and vaccinations within seven days of their admission. An interview with the registered nurse (RN) confirmed the program has an exposure control plan and infection control policy and they are responsible for training staff on both the plan/policy and on an annual basis. The RN also indicated the nursing staff provide infection control training to the youth at admission.

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, the 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.	

Documentation revealed the program has a written policy and procedures for active supervision of youth. According to the written policy and procedures, staff to youth ratios are as follows: 1:8 during awake hours, 1:10 during sleep hours, and 1:5 for vocational activities. Observations, informal interviews, log book entries, on-site observations, and video reviews confirmed youth to staff ratios were in compliance. Staff were able to immediately inform the annual compliance review team member how many youth were under their supervision when asked. Observations throughout the annual compliance review by the review team members on-site through-out the week found youth reading educational materials, as scheduled, and participating in meals, breaks, and line movements. Positive interactions were observed between youth and staff. The posted schedule was full of activities. On-site observations during the annual compliance review by the review team members found the schedule was followed. At no time during the annual compliance review were youth observed wandering freely about the program. Each of the five interviewed staff confirmed their understanding of the procedures when there is a discrepancy with the count. All of the staff indicated the count is reconducted until the count is reconciled. Observations, informal interviews, log book entries, and video reviews confirmed counts were conducted at scheduled and unscheduled times.

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.*	

Documentation confirmed the program has a detailed written description of the collaborative behavior management system (BMS). The program utilizes the BMS to foster accountability for behavior and compliance with the program's rules and expectations. The program's BMS consists of four levels, which is designed to positively reinforce pro-social behaviors and reduce anti-social behaviors. The youth earn points, which are documented on a level system evaluation form. The BMS was observed posted on the living spaces and is clearly explained in the program handbook which is accessible to youth. The program's BMS details the rules and the positive and negative consequences for actions. Ten training records were reviewed. All staff training records contained BMS training. All five interviewed staff confirmed training and understanding of the BMS. Informal interviews with staff during the annual compliance review week confirmed their understanding and implementation of the BMS. The orientation checklist documents the BMS is reviewed with the youth. All youth case management records contained a complete orientation checklist. The BMS promotes youth rights, positive, negative consequences, constructive disciplinary action, opportunities for reinforcement, provide youth

with pro-social acceptable alternative behavior. The youth have an opportunity to explain their behavior. The BMS is connected to the youth's individual performance and treatment plan goals. The BMS includes a variety of rewards including daily snacks, verbal praise, special privilege activities, and off campus incentive trips. The executive director interview confirmed the BMS is a level/point system with daily and weekly incentives. All five interviewed youth confirmed their understanding of the BMS. The program provides opportunities for positive reinforcement and recognition of accomplishments and positive behaviors at a minimum ratio of four-to-one (4:1) positive to negative consequences. Five youth rated the BMS as being very good. Five interviewed staff were able to summarize the BMS process, as well as give examples of rewards and incentives given to youth. All five staff indicated only privileges can be taken away from youth as a result of negative behaviors exhibited.

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.*	

A review of the program's written policy and procedures for the behavior management system (BMS) ensured there was a protocol where staff are provided feedback regarding their implementation of the BMS. Feedback is delivered through monthly staff meetings, on-going training, and performance evaluations. Ten staff training records were reviewed. All ten staff received pre-service training for the BMS. Five received in-service training for the BMS. A review of position descriptions specifying required qualifications of staff whose job functions includes implementation of the program's BMS. The qualifications varied by position from high school diploma to college degrees. The program's BMS includes a process wherein staff explain to the youth the reason for any sanction impose. A review of the provider's contractual agreement confirmed all required parties were involved in the development, implementation, and on-going maintenance of the BMS. The program does not utilize room restriction as indicated in their policy. The BMS does not include increased length of stay, denial of youth basic right, promotion of group punishment, punishment by other youth, or disciplinary confinement. Education staff are paid for through the provider and are trained in the BMS. Five interviewed staff were able to summarize the BMS process. The program uses several methods to ensure the BMS is used fairly and effectively, which include monitoring point cards during treatment meetings, discussing the use of point cards during monthly supervisor's meetings, and daily staff debrief sessions, this ensures the system is not being used to increase a youth's length of stay. When the youth disagree with points assigned or lost, the point cards are reviewed by the executive director, with the youth and staff are present. All five staff indicated only privileges can be taken away from youth as a result of negative behaviors exhibited. All staff explained youth are informed of the consequences and are able to explain their behaviors. Each of the five interviewed staff indicated they received feedback on their implementation of the BMS daily and as needed. Five youth were interviewed concerning the staff's implementation of the BMS. Five youth explained staff were consistent. The executive

director interview confirmed consequences are monitored during the morning management meeting, as well as during special and regular treatment teams. The program's BMS is not used solely to increase a youth's length of stay. Behaviors positive and negative are reviewed during treatment teams.

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.	

Documentation indicates the program has twenty cameras. Twenty cameras were operational at the time of this review. The video coverage storage goes back thirty days. The program's practice is to conduct checks every eight minutes. A review of the hard copy of electronic checks (The Guard One Touch System wand) was utilized to review ten-minute checks on third shift. The sampling included a random date selected for November, December, January, February, March, April, and May. A total of over fifty-six ten-minute checks were completed with no issues. The video was reviewed on different dates and various times on each shift in April and May. A total of forty-eight ten-minute checks were completed with no issues. Each of the five interviewed staff indicated checks are complete at eight-minute intervals.

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.*	

Documentation confirmed youth are always accounted for through a system of physically counting youth at various times throughout the day in accordance with the program's policy and procedures. The program tracks daily census information including the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program in the logbooks. A review of the program's logbooks included a random date selected for November 2019, December 2019, January, February, March, April, and May 2020. All three shifts were reviewed for each random date and no discrepancies were found. Informal and formal counts were observed during the annual compliance review and found they were each conducted as required. Five staff interviews confirm staff know the procedures for reconciling

the count if there is a discrepancy. They also indicate counts are conducted at beginning of shift, outside activities, and major disruptions.

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

The program has a policy and procedures to address logbooks. Logbooks from November 2019 to May 2020 were reviewed. All the logbooks were bound. All entries were in ink. There was no evidence of eraser marks. None of the pages were removed or obliterated. Each logbook covers a one-month period. The logbook pages documented perimeter checks, weather alerts, Central Communications Center (CCC) reports, shift summary notes, keys, radios, drills, Prison Rape Elimination Act (PREA) checks, fire safety, and scheduled and unscheduled counts, and any calls made to the Florida Abuse Hotline and CCC. The program does not maintain a living unit logbook. Three incidents on, January 3, 2020, February 23, 2020 and March 26, 2020 were reviewed. Documentation confirmed these incidents were reported to the CCC and noted in the logbooks.

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*	

Documentation confirmed the program has a system to govern the control and the use of keys. The program's written policy and procedures addressed distribution, tracking, storage, and overall control and security of keys. A review of the inventory matched the key rings in use. The keys are kept in a secure area in the master control area which is not accessible to youth. Each set of keys has an assigned key hook. Keys are assigned to staff according to their department. The master control operator reported restricted keys, temporary keys, and visitor keys are all kept separate from each other. There were no reports of broken or damaged keys. There were no incidents of lost keys, which was verified by the review of internal incident reports and Central Communications Center (CCC) reports. The maintenance manager is responsible for replacing broken or damaged keys. Informal interviews with staff confirmed staff's knowledge of the key rings and assigned keys. All observations during the annual compliance review week found personal keys were secured and staff were aware of program keys in their possession and followed the key control procedures. A sampling of three staff keys was completed to compare their key rings to the key inventory logs with no issues identified. All five interviewed staff confirmed staff knowledge of and implementation of key control policies and procedures. Additionally, staff reported if keys were damaged, they would notify their supervisor and submit a maintenance request.

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.

Documentation confirmed the program has a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and youth which is clearly explained in the program's policy and procedures, and resident handbook. The policy includes any staff who is found in possession of contraband in a program will be subject to disciplinary action up to, and including, dismissal. The program defines items and materials considered contraband when found in the possession of youth, provides youth with a list of contraband, and informs youth of the consequences if found with contraband. The prohibited list includes personal cell phones and/or equipment and/or electronic devices capable of taking pictures and/or audio/video recordings, which are prohibited in the secure area. Staff were able to explain the contraband procedures. The contraband notice is posted on the front gate and states law enforcement will be contacted for anyone bringing in contraband. All searches are documented in search binders (visitation, room, and youth). The binders were reviewed and found searches were documented appropriately. The log books from November 2019, December 2019, February 2020, and March 2020 were reviewed. Documentation confirmed youth are fully searched for contraband after every movement. Observations during the annual review period indicated youth are fully searched after every movement.

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.

Documentation confirmed the program has written policy and procedures addressing searches. Observations during the annual compliance review found searches were completed prior to and after movement from one area to another. Observations found searches were conducted in a manner which treated the youth with dignity and respect. Searches were conducted in accordance with Protective Action Response (PAR) training manual. Five staff were interviewed and indicated all searches are conducted by same gender as staff for all movements throughout

the day. Full body visual searches are done for admissions or youth returning from off-site activity. Five youth were interviewed and indicated searches are done when returning from off-site, after outings, meals, visitation, recreation during and work details.

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

The program has one fifteen passenger van. The program has alternative measures to obtain more vechicles in the event of an evacuation.The van had an annual safety inspection on February 4, 2020. The van observed was secured when not in use. A random check confirmed the van is secured when not in use. The van contained a fire extinguisher, seal belt cutter, window punch, and appropriate number of seat belts. The van had an assigned first aid kit which is kept in master control. The program did not have any transports scheduled during review period; however, an informal interview with staff and youth indicated while on transports all occupants wear seatbelts. During transports youth are not attached to any part of the vehicle other than proper use of a seat belt. Five staff and youth were interviewed and reported the all wear seatbelts. Staff also indicated they are provided a cell phone while on transports. All five interviewed staff confirmed youth are not transported in staff's personal vehicles.

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's written policy and procedures were reviewed and found to ensure compliance of all requirements outlined by the Department relating to transportation of youth and driver eligibility (FDJJ 1920). A transport was not observed. Informal interview of staff confirmed the understanding of the 1:5 staff-to-youth ratio while transporting youth. A check of all the cars in the parking lot found all the cars were locked. An approved driver list was observed posted in the master control with staff who have current valid driver's licenses. The transport binder was reviewed. All transport orders were filled out and documented searches and vehicle's safety, ratio maintained during transports, cell phone, and transporters of same gender as youth. Five of five staff interviewed confirmed youth are not transported in staff's personal vehicles. Additionally, staff reported they are issued a program cell phone when going on transport.

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

The written policy and procedures clearly designate the maintenance manager for conducting the weekly security safety and security audits. Weekly audits binder reviewed. The program has two forms used to document weekly inspections. The forms documented safety and maintenance repairs needed and the date and time the repairs were completed. The weekly safety audits are kept in a binder. All the forms were reviewed and signed by the executive

director. The forms cover radios, cameras, keys, telephones, mechanical restraints, generator, flashlights, fire safety equipment, alarms, ensuring no anchor points, youth rooms, recreation area, grounds, correction action needed, and corrective action completed. A review of sample weekly safety and security audit documents reveals they are being completed every seven days. The interview completed by the executive director confirmed the weekly safety audits are conducted in accordance with program policy and procedures.

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 in place to ensure youth use of tools safely and youth are supervised appropriately to prevent injuries to the youth, other youth, and staff. All observations during the annual compliance review week found all tools were secured when not in use. Class B tools, mops, and brooms are in a closet by the bathroom on the dorm and in the kitchen. The inventories and sign-in-sheets for the previous six months were reviewed. All the Class B tools matched the inventory. Class A tools are in the kitchen in a locked cabinet in the food manager office and in the maintenance area, which are both areas not accessible to youth. The Class A tools are on shadow boards. The Class A tools are inventoried. The inventories and sign-in out tools for the previous six months were reviewed and were complete. A random check of Class A tools in the kitchen and in the maintenance area was conducted and found all items matched the inventory lists. The maintenance manager indicated there have not been any reports of damaged or dysfunctional tools. Five youth were interviewed and indicated they only use brush and mops. Five staff interviews confirmed youth do not have access to any unapproved tools.

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

The program has a policy and procedures in place to ensure youth tools handling is safe and are supervised appropriately. A review of five youth records confirmed youth are given an assessment to determine the level of tool access. The youth on levels three and four of the behavior management system are permitted to participate in vocational training and work projects, which would include the use of Class "A" tools. Five youth and staff were interviewed and indicated youth do not have any access to any tools without supervision.

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

Documentation reveals the program's written policy and procedures address when an outside contractor enters the program to perform a work project requiring the use of tools. The program restricts tools to those necessary, checks tools upon the contractor's arrival and departure, restricts youth access to the work area, ensures immediate reporting of any tool the worker cannot locate, and follows up if any tool is missing. Personal cellular phones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area. The program's policy and procedures outline who is responsible

for providing approval/permissions if such items are required. The program maintains a binder which contains all notice of tools equipment instructions forms which the outside contractor must sign. The binder was reviewed. The dates of the work invoices matched the sign-in sheets of the outside contractors. The tool notice forms also addresses the following: tools checked upon arrival and departure, tool restrictions while in the program, youth are restricted from the work area, and missing tool follow-up. Outside contractors are required to sign the notice of tool equipment instructions form.

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.	

Drills are conducted in accordance with the program's disaster plan or Continuity of Operations Plan (COOP). A review of the fire, safety, evacuation, and disaster drill between November 1, 2019 to May 7, 2020 was completed. Fire drills were conducted three times a month ensuring all shifts participate, exceeding the required monthly drills. Additionally, other safety, evacuation, and disaster drills, covering natural disasters, and evacuations were completed within the past twelve months. An interview with the executive director confirmed, they have at least three fire, safety, and evacuation drills monthly. Five staff were interviewed, and confirmed fire, safety and evacuation drills were conducted on a monthly basis. Five youth were interviewed and confirmed they have been instructed on the fire evacuation process. Fire evacuation routes and egress plans were posted throughout the program.

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 Continuity of Operations Plan (COOP) is located in master control and executive director's office. The plan addresses alternative housing plans approved by the applicable Department of Juvenile Justice (DJJ) regional director/designee. The plan was approved by the residential regional director on March 10, 2020. The COOP addresses: fire prevention and evacuation, severe weather, program disturbances, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The program conducts COOP drills on each shift. The drill documentation included: type of drill, date and time of the drill, participants, brief scenario and findings/recommendations, and pictures. The drills included natural disasters, program disturbances, chemical spills, active shooter, and evacuation severe weather. The program has food and necessary supplies readily available in case of emergency evacuation. The executive director reported the COOP is located in master control and in the FA's office.

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

The program has a policy and procedures in place to ensure inventory and strict control is maintained over flammable, poisonous, toxic items, and materials. The Safety Data Sheets (SDS) and current storage of poisonous, flammable, and toxic materials were observed. All flammable, poisonous and toxic items were secured in a locked shed, within a locked fence outside the facility. Poisonous items inside the program were stored in a locked cabinet, inside the locked laundry room, and were clearly marked on the inventory sheets and SDS sheets, which were accurate and current.

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

The program maintains strict control of flammable, poisonous, and toxic items and materials. The program policy procedures indicate youth are not allowed to or have access to chemicals. Observations throughout the review week confirmed the youth do not use or have access to the chemicals. Five youth were interviewed regarding the use of these materials. Each of the five interviewed youth reported they do not use any chemicals. All five interviewed staff reported youth do not use chemicals.

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 policy and procedures in place to ensure the maintenance mechanic has the safety equipment and procedures for handling and disposing of hazardous waste and/or solid waste and toxic materials. All hazardous material inside the shed and cabinet were listed on the Safety Data Sheet (SDS), according to standard requirements. The executive director and the maintenance mechanic stated the maintenance mechanic takes all hazardous materials to the local waste management site to properly dispose of hazardous items, toxic substance, and chemicals in accordance with Occupational Safety and Health Administration (OSHA).

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

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

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

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

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

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

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

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

The visitation procedures are posted on the front gate and on the wall in the lobby. The visitation and communication procedures are covered in the resident handbook and addressed on the orientation checklist. A review of the visitation, mail, telephone log, and schedule was conducted to confirm the program’s practice. Youth are given an opportunity communicate with family members through visitation, mail, and telephone calls. Searches of in-coming and outgoing mail is completed by staff in the presence of youth. Each youth receives a youth handbook upon admission, which details visitation, telephone, and mail procedures. Seven interviewed youth all reported they have the opportunity to communicate with their families through these means. The weekly telephone calls to parents/guardians are documented in the youth case management records in the chronological notes. Five youth case management

records were reviewed. All contained documentation of weekly phone calls to parents/guardians or family members. Each of the five interviewed youth confirmed they have opportunities to contact their family by telephone and during visitation. Visitation is held on weekends and was not able to be observed during the annual compliance review since visitation was suspended on March 15, 2020 due to the COVID-19 pandemic.

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, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

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

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

The program's policy, procedure, and practice confirm 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 has a safety planning process in place for each youth. The safety plan is designed to identify stimuli which have both positive and negative effects on the youth. All safety plans located in the youth's record for all five youth were reviewed. The current safety plan for each youth is maintained in a binder centrally located for staff access. The overall Trauma-Informed Individualized Safety Plan form addresses the youth's crisis recognition but does not specifically address the staff's perception of verbal and non-verbal stimuli that have both positive and negative effects on the youth. The form does not document the fact the youth's coping skills were developed as a joint effort between the staff and the youth. The program reported using various methods to address coping skills with the youth to include therapeutic groups and addressing coping skills during the youth's formal treatment team meetings. The safety plans completed prior to January do not have individual staff signatures of the treatment team to support the plan was jointly prepared by the youth, parent/guardian, and clinical staff. The program revised the form in January to include this information. All signatures were included on the safety plans completed after January. There is section of the safety plan to document the parent/guardian participated in completion of the safety plan. The majority of the plans either

had this section marked “No” or this section was left blank. The program indicated the safety planning process was updated to capture parent/guardian participation and attempted parent/guardian contact on the youth’s initial treatment plan. If the parent/guardian is unable to participate in the completion of the safety plan, a blank parent/guardian response form is mailed out to the parent/guardian at intake so they can provide input into the youth’s safety plan. The safety plans shall incorporate any recommendations from previous or current clinical assessments or screening instruments. On the newer safety plans completed since December, there is a section on the safety plan addressing this requirement. This section was left blank on five safety plans for one individual youth. The safety plan must be updated every thirty days or following any significant behavioral or mental health events identified by the youth’s intervention and treatment team. There were three youth who did not receive an updated safety plan on a monthly basis. One youth who entered the program in October of 2019 had safety plan revisions completed monthly except for the month of November 2019. Another youth who entered the program in October of 2019 had safety plan revisions completed monthly except for the months of November through February. The third youth who entered the program in November of 2019 had safety plan revisions completed monthly except for the months of December through February. The program confirmed these did not require any safety plan revisions for those months. Five youth indicated all were involved in the development of their safety plan. Five staff surveys indicated the safety plans are located in master control, are updated monthly, and staff can view them when needed.