STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

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

Review Date(s): June 4 -7, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Marvin D. Bliss, Office of Program Accountability, Lead Reviewer (Standard 1)
Brenda Comadore, Office of Program Accountability, Regional Monitor (Standard 5)
Donna Connors, Office of Program Accountability, Regional Monitor (Standard 4)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 2)
Joey Nice, Department of Juvenile Justice, West Region Education Coordinator (Education)
Paul Sheffer, Office of Program Accountability, Regional Monitor (Standard 3)
Jonathan Thompson, Office of Program Accountability, Regional Monitor (Standard 4)
Jake Turley, TrueCore Behavioral Solutions, Information System Project Manager (Standard 5)

Program Name: Charles Britt Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Pinellas County / Circuit 6
Review Date(s): June 4-7, 2019

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

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- 2 # Case Managers
- 2 # Clinical Staff
- 1 # Food Service Personnel
- 1 # Healthcare Staff
- 1 # Maintenance Personnel
- 3 # Program Supervisors
- 5 # Staff
- 5 # Youth
- _____ # Other (listed by title): _____

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☐ Confinement Reports
- ☒ Continuity of Operation Plan
- ☒ Contract Monitoring Reports
- ☒ Contract Scope of Services
- ☒ Egress Plans
- ☐ Escape Notification/Logs
- ☒ Exposure Control Plan
- ☒ Fire Drill Log
- ☐ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☒ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Sick Call Logs
- ☒ Supplemental Contracts
- ☒ Table of Organization
- ☒ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☒ Visitation Logs
- ☒ Youth Handbook
- 5 # Health Records
- 5 # MH/SA Records
- 30 # Personnel Records
- 30 # Training Records/CORE
- 3 # Youth Records (Closed)
- 5 # Youth Records (Open)
- _____ # Other: _____

Observations During Review

- ☐ Admissions
- ☐ Confinement
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☒ Group
- ☐ Meals
- ☒ Medical Clinic
- ☒ Medication Administration
- ☒ Posting of Abuse Hotline
- ☒ Program Activities
- ☒ Recreation
- ☒ Searches
- ☒ Security Video Tapes
- ☒ Sick Call
- ☒ Social Skill Modeling by Staff
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Transition/Exit Conferences
- ☐ Treatment Team Meetings
- ☐ Use of Mechanical Restraints
- ☒ Youth Movement and Counts

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Room Restriction/Controlled Observation	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The 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 (SAT overlay services). The youth receive substance abuse treatment, social and life skills, vocational training, and on-site educational classes. In addition, the program fosters each youth by providing delinquency intervention services for the youth, which include 'Impact of Crime' (IOC), 'Thinking for A Change' (T4C), and the 'Council for Boys and Young Men'. 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 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.

Strengths and Innovative Approaches

- The program has partnered with a local hospital for the past two years to offer parenting classes to youth who have a child or are expecting a child. This class is offered as needed.

- The program has planted a victim garden, which is maintained by the youth and staff daily. Youth maintain the victim garden by planting trees, shrubs and flowers in the designated space on the recreation field. A path of stones has been laid down leading people through the garden to a bench sitting area. Youth can request to visit the garden if the they need to cool off or think. The garden is also used for therapeutic sessions by mental health.

Standard 1: Management Accountability

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

The program has a policy and procedures in place regarding initial background screenings. Initial background screenings are conducted for all new employees, interns, volunteers, and mentors. Sixteen staff were hired since the last annual compliance review and each had a background screening completed prior to their start date. Additionally, all sixteen of the employees hired were direct care staff eligible for a pre-employment assessment tool. Each of the sixteen staff completed the pre-employment assessment tool and received a passing score. The program also reviews each staff's criminal history report, the Central Communications Center person involvement report, Staff Verification System, and the Florida Department of Law Enforcement's background screening results. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Background Screening Unit on January 3, 2019 meeting the annual requirement. The teachers are employed by the program's provider; Pinellas County School Board; therefore, the clearances are provided through the school board. There were no new volunteers including mentors and interns eligible for a pre-screening.

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 regarding a five-year rescreening based on the initial date of employment. Three employees were eligible for a five-year rescreening, and each rescreening was completed prior to the five-year anniversary date.

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

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

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

The program has a policy and procedures in place regarding the provision of an abuse-free environment. The program's facility operating procedures indicated the program will comply with and support the Department's policy on abuse reporting, all allegations of child abuse or suspected child abuse will be immediately reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC) within two hours of the incident. All staff are to be trained in reporting procedures. The policy also indicates the program will allow unhindered access for youth and staff to make the decision to report allegations of abuse. Youth are granted immediate access to make a call by using a phone located in the multi-purpose room, which has direct access to the Florida Abuse Hotline. Youth eighteen years or older, must go through staff to obtain use of a phone to call the CCC hot line, staff will dial the number and then permit the youth to speak with the operator. At the end of the call, the staff member will speak with the operator to get the operator identification number and incident number, if one is assigned. The on-duty supervisor is responsible for notifying the executive director of the incident and contacting the CCC. A review incidents since the last annual compliance review reflected no calls to the abuse registry. Five youth were interviewed, and all reported they feel safe and have never been denied a call to the Florida Abuse Hotline. Five youth were asked if they have heard staff use profanity, all youth said never. Five staff were interviewed regarding if they observed a co-worked informing a youth they could not make a call to the Florida Abuse Hotline and all indicated they had not. All interviewed staff also indicated they had never observed a co-worker using profanity when speaking to a youth, using threats, intimidation or humiliation when interacting with youth. The executive director indicated they ensure staff are trained on how to appropriately interact with youth and one another. If there are reportable incidents which occur, staff are trained to report those incidents immediately. If there is imminent danger, staff will be removed from youth contact.

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

The program has a policy and procedures for responding to allegations of physical, psychological, or emotional abuse by staff and youth. The program had no closed incidents of substantiated abuse since the last annual compliance review and one open report with the Department's Central Communications Center (CCC) for Use of Force currently under investigation. The executive director indicated during all pending investigations, staff will be removed from contact with the youth.

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

The program has a policy and procedures for reporting incidents to the Central Communications Center (CCC). There were eight incidents reported to the CCC in the past six months. All eight of these calls were reviewed and found each incident was reported within two hours and documented in the logbooks. There were no internal incidents or grievances which should have been reported to the CCC. The program has not experienced an increase in the number of reportable incidents to the CCC. The executive director explained if a reportable incident occurs, the Florida Abuse Hotline is notified, as well as the CCC, and if warranted, the police department is notified. All notifications must be made within the two-hour time frame. If the incident is Prison Rape Elimination Act (PREA) related, the PREA policy will be implemented. Additionally, both pre and in-service training includes incident reporting, where the program's policy is reviewed. Youth are informed of the reporting process through the orientation and intake process, as well as during townhall meetings.

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

The program has a policy and procedures for the use of physical intervention techniques in accordance with Florida Administrative Code. The program's Protective Action Response (PAR) plan has been approved by the Department. The program has not experienced an increase in the number of PARs since the last annual compliance review. There were only two PAR incidents for the past year which were completed by the end of each staff member's workday and included statements from all staff involved. None of the reports indicated any injuries were sustained to the youth or staff, nor did the youth allege abuse. In both reports, a PAR certified instructor or supervisory staff completed a review and a post-PAR interview with the youth was conducted, all completed within the required time frames. All PAR reports are maintained in a central file. The executive director stated PAR reports are completed and reviewed utilizing

closed-circuit television (CCTV), if footage is available, to ensure staff are properly utilizing techniques according to policy. The program's PAR rate for the current quarter was 0.27, which is below the statewide average of 1.55.

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

The program has a policy and procedures in place regarding pre-service training requirements for staff during the initial 180 days of employment. The program submitted, in writing, a list of pre-service trainings to the Department's Office of Staff Development and Training, including course names, descriptions, objectives, and training hours for all instructor-led training. The training plan was approved on January 3, 2019. Five staff training records were reviewed. Each of the staff were certified within 180 days of hire and completed more than the required 120 hours of pre-service training. All five records included documentation of the required trainings including professionalism and ethics, Protective Action Response (PAR), suicide prevention, emergency procedures, cardiopulmonary resuscitation (CPR), first aid, use of an automated external defibrillator (AED), child abuse reporting, and Prison Rape Elimination Act (PREA). All instructors providing training were qualified to do so. Trainings were documented in the Department's Learning Management System (SkillPro).

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

The program has a policy and procedures in place regarding in-service training requirements for staff. The five staff training records were reviewed and revealed all had forty hours or more in training which exceeded the twenty-four-hour requirement. There was documentation in each record to support the staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), and Protective Action Response (PAR). All staff received CPR refresher training on an annual basis. There was documentation to support all five-staff received annual training in ethics, child abuse reporting and suicide prevention. The program submitted, in writing, a list of in-service training to the Office of Staff Development and Training including course names, descriptions, objectives, and training hours for instructor-led training on January 3, 2019. Three of the five training records were supervisors; two had forty hours of training and one had sixty hours of training in addition to the required eight hours of supervisory training.

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, including training requirements, regarding the grievance process. The program's grievance process includes an informal, formal, and the appeal phases. The informal phase is accomplished through a "speak out" form which is checked by each shift supervisor. If not resolved in this phase, the youth may submit a formal grievance to the supervisor. The supervisor has four days to review, investigate, and respond to the youth. If the youth is not satisfied with the response, it may be appealed to the assistant facility administrator, who will have twenty-four hours to respond, and then the executive director, who has forty-eight hours to respond. The program maintains copies of the grievances in a grievance binder. In the past six months, there have been two grievances filed. Each of the grievances reviewed were resolved during the formal phase and within twenty-four hours of the youth filing the grievance. Five youth were interviewed and were able to explain the process for completing a grievance. Five staff were interviewed and reported youth may request assistance in completing the grievance form. The executive director confirmed the process for grievances to include three phases and the time frames associated with each phase.

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

The program has a policy and procedures in place regarding restorative justice awareness for youth. The program conducts Impact of Crime (IOC), Thinking for A Change (T4C), and the Council for Boys and Young Men groups twice a week. These curriculums assist youth in accepting responsibility for harm they have caused by their past criminal actions and challenges them to modify their thinking. The youth are also provided opportunities to plan and participate in restitution activities, community service projects, and maintain a victim garden. Youth maintain the victim garden by planting trees, shrubs, and flowers in the designated space on the recreation field. A path of stones has been laid down leading people through the garden to a bench sitting area. Youth can request to visit the garden if the they need to cool off or think. The mental health staff also use the garden for therapeutic sessions with the youth. Staff currently providing the IOC, T4C and the Council for Boys and Young Men curriculums have received the required training. Group sign-in sheets supported the curriculums were delivered throughout the year and the current groups started in April of 2019. Five youth records were reviewed, and documentation supported youth received services to increase their accountability for criminal actions and harm to others. An interview with the executive director indicated youth are attending both T4C and IOC, which are being offered at the same time as well as receive the Council for Boys and Young Men on Saturday and Sunday each week.

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

The program has a policy regarding life skills training provided to youth. The executive director explained when determining which staff will deliver life skills trainings or groups, education and experience are considered. Additionally, he stated youth are assigned to the perspective staff, case managers, and intervention groups according to their individualized needs and priorities. The program is providing structured, planned programming or activities at least sixty percent of the youth's awake hours. Staff members providing, Thinking for a Change (T4C), Life Skills training (LST) and Council for Boys and Young Men received the required training to facilitate the groups. A review of sign-in sheets confirmed groups were delivered, as required. Groups are scheduled seven days a week. Five youth records were reviewed, and confirm youth are receiving services as outlined in their treatment and performance plans. Five youth were interviewed and indicated they participate in life skills training. Youth also indicated they have learned coping skills through participation in the groups to include thought stopping and relapse prevention.

1.12 Restorative Justice Awareness for Youth	Satisfactory Compliance
The program shall provide activities or instruction intended to increase youth awareness of, and empathy for, crime victims and survivors, and increase personal accountability for youths' criminal actions and harm to others.	

The program has a policy and procedures in place regarding restorative justice awareness for youth. The program uses the Impact of Crime (IOC) curriculum The curriculums assist youth in accepting responsibility for harm they have caused by their past criminal actions and challenges them to modify their irresponsible thinking. The youth are also provided opportunities to plan and participate in restitution activities, community service projects, and maintain a victim garden. Youth maintain the victim garden by planting trees, shrubs and flowers in the designated space on the recreation field. A path of stones has been laid down leading people through the garden to a bench sitting area. Youth can request to visit the garden if the they need to cool off or think. The mental health staff also use the garden for therapeutic sessions with the youth. Staff currently providing the IOC curriculum have received the required training to facilitate the groups. Group sign-in sheets supported the curriculum was delivered, as designed. Five youth records were reviewed, and documentation supported youth received services to increase their accountability for criminal actions and harm to others. Youth participate in IOC groups, which occurs two days a week. An interview with the executive director indicated youth are attending the IOC, which are being offered at the same time as well as receive the Council for Boys and Young Men.

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

The program has a written policy and procedures to address the provision of gender-specific programming. The program uses the The Council for Boys and Young Men and Say it Straight curricula for gender-specific interventions. The sign-in sheets for both groups were reviewed. The youth received information on male social norms, healthy relationships, building positive

friendships, bullying, teen pregnancy, and sexually transmitted infection prevention. There was documentation to support all five-youth received gender-specific health instruction from the program's registered nurse. An interview with the executive director, confirmed the gender-specific programming groups are provided for the youth.

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 to determine how alerts are identified, documented, updated, and communicated to staff. The executive director explained management reviews alerts daily and as new alerts are identified, they are updated into the system. The program has an internal alert board where youth pictures are posted with a color-coded system to identify various alerts. There is also an alert sheet which is updated, as needed, and posted in the kitchen for youth with food allergies. All alerts are also documented in the logbook, staff are required to sign the logbook at the beginning of each shift indicating they are aware of all alerts. The manager for each respective department is responsible for ensuring alerts for youth are updated and entered into the Department's Juvenile Justice Information System (JJIS). Youth who had alerts for suicide risk entered into JJIS reflected the alert was updated and removed, as required by the clinical director. A comparison of internal alerts and alerts in JJIS reflected no inconsistencies. All five- youth reviewed had medication alerts which were entered into JJIS as required

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 an official case record, labeled "Confidential," for each youth. The program separates the youth record into an individual management record, health care record, and mental health/substance abuse record. The individual management record is labeled with the youth's name, Department identification number, date of birth, county of residence, and committing offense. The individual management record contains the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. Youth records are stored in a locked room.

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

The program has a policy and procedures which addresses a formal process to promote constructive input by youth. The program accomplishes this through youth advisory board meetings and student council meetings. Five youth were interviewed regarding how they are able to provide input into programming. All five-youth indicated they use “Speak Out” forms to voice concerns. The executive director indicated youth complete monthly interviews, as well as exit interviews to make recommendations to improve conditions and enhance the quality of life for staff and youth in the program. Additionally, the executive director indicated community meetings/student council meetings are conducted to provide youth a forum to voice their concerns, issues, and program feedback on a monthly basis or as special needs arise.

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

The program has a written policy and procedures 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. There was a community board meeting each quarter since the previous annual compliance review. Meetings were held in May, September, and December 2018, and March 2019. 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 executive director explained all-staff meetings are held once a month and as-needed. Additionally, to assist with employee morale, the program has an employee of the month and weekly staff appreciation events. The executive director explained how data is used for future program planning including the use of youth and parent interviews and employee satisfaction interviews. Results are discussed with staff and improvements are made with any deficiencies noted. Information is shared, such as published reports, during monthly staff meetings. Five staff were interviewed, and all said staff meetings are held monthly. Staff reported topics included the behavior management system, day-to-day operations, upcoming trainings, dress code, family events, review of state information or reports and youth issues, as well as, a review

of drills. All six-staff confirmed they are briefed on reports, annual compliance reports, and youth and parent/guardian interviews. Two reported the system of receiving information is good, and three reported it is very good. Documentation supported monthly staff meetings are held to inform staff on various topics such as behavior management system, grievance procedures, evaluation sheets, key control, etc. Additionally, monthly management meetings are held for administrative staff to review department updates.

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 regarding staff performance and evaluations, which states staff will be evaluated after their initial ninety-day probationary period and annually thereafter. A review of five personnel records found each contained copies of job descriptions which clearly identified performance standards. A review of five performance evaluations reflected they were completed in a timely manner. The performance standards matched the job descriptions for each staff. The evaluation form also includes a section for those staff members who facilitate an evidenced based group. Five staff members were interviewed and all reported receiving a ninety-day performance evaluation and a performance evaluation annually.

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 to provide for making initial contacts with the committing court, juvenile probation officer, post residential counselor, if applicable, and parent/guardian. A review of five youth records found documentation the parent/guardian, committing court, juvenile probation officer (JPO) and post residential counselor (if applicable) received a contact from the facility the day of admission. Documentation reviewed indicated the youth's parent/guardian were notified by phone within twenty-four hours of admission and in writing within forty-eight hours. In addition, each record documented court and juvenile probation officer notification within the five-day required time frame.

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 to provide orientation to youth. A review of five youth records contained documentation to confirm orientation began on the day of admission and included services available, daily schedule, expectation and responsibilities of youth, behavior management system, availability of medical and mental health services, access to the Florida Abuse Hotline access or Central Communications Center, illegal contraband items, performance planning process, dress code and hygiene, visitation, mail and telephone procedures, anticipated length of stay, community access, grievance procedures, emergency procedures, physical design of the facility, and assignment to a living unit, room, treatment team or group. At the time of the annual compliance review, there were no admissions for the reviewer to observe. Five youth interviews indicated youth received orientation into the facility with-in twenty-four hours of being admitted.

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 to provide for written consent for eighteen-year-old youth. The program had three applicable youth at the time of the annual compliance review. A review of each record revealed each youth had a signed copy of release of information to the respective parent/guardian.

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

The program has a policy and procedures to provide for classification, room assignment and reassessments. A review of five youth records revealed each youth received a risk classification which included physical characteristics, age, maturity level, special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization. In addition, each youth was assessed for risk related to suicide, medical, escape, or security. An interview with the facility administrator indicated the therapist, case manager, and the clinical director review each youth's history to include mental health status, physical health status, cognitive performance, age, and prior victimization are documented and included when assigning a youth to a living unit prior to youth's arrival. During intake, the treatment team takes into consideration the youth's presentation, age, and level of functioning before placing the youth on a living unit. All five reviewed records documented how the youth were assigned to a living unit/room based on the program's classification system. Each of the five reviewed youth records indicated each youth was at risk for escape and were classified as a security risk based on their history and current assessment. The program utilizes an alert system, which provides staff updated classification information on each youth's alert status for medical, mental health, suicide, sexual aggression. All five of the youth received a follow-up classification risk assessment within two weeks and reclassification finding youth no longer at risk for escape or security risk. In addition, each record contained a risk assessment completed monthly regarding youth permission for use of tools, and off campus trips. Interviews with administration revealed all newly admitted youth are given a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening and all factors (mental health, physical health status, cognitive performance, age, size, and prior victimization) are considered before assigning a youth to a room.

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 to provide for gang identification and notification to law enforcement. There were three youth identified as gang members or associates, two were identified prior to admission and entered into the Juvenile Justice Information System (JJIS) and one was identified on-site and entered into the JJIS system. For the youth identified on-site, records documented written notification to local law enforcement, education provider, juvenile probation officer and law enforcement in the youth's home of record. There was verification of an alert being entered into JJIS for all three youth.

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

The program has a policy and procedures to provide for prevention and intervention activities for youth involved with gangs. The program uses screenings, assessments, the classification process, and the Department's Juvenile Justice Information System (JJIS) to help identify youth requiring participation in gang prevention or intervention activities. The program includes a gang experience questionnaire for each youth admission to screen for applicable youth. The questionnaire was found completed in all five reviewed records. The program has an individual identified as a gang liaison who is involved in the development and implementation of the program's gang preventions overall strategy. Three of the five youth screened applicable for gang prevention and intervention activities. A review of the gang binder revealed meetings were conducted each month for the review period. All three-applicable youth attended each of the monthly meetings. Subjects included letters of apology to the community, myths and reality, gang awareness, and gang resistance. Each applicable youth performance plan included a gang related goal.

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

The program has a policy and procedures to provide for Residential Positive Achievement Change Tool (R-PACT). Each of the five records included an initial R-PACT assessment completed in the Department's Juvenile Justice Information System (JJIS) within thirty days of the youth's admission. Each record included a hard copy of the initial R-PACT. All five youth records were applicable for R-PACT Reassessments, all reassessments were documented in JJIS and in the case management records and completed within ninety days of the completion of the youth's initial R-PACT assessment.

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

The program has a policy and procedures to provide the Youth Needs Assessment (YNAS). A review of five youth records revealed each youth received a YNAS within thirty days of admission. Each assessment was maintained in the Juvenile Justice Information System.

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

The program has a policy and procedures to provide for performance plan development. There was documentation the treatment leader, youth, administrative representative, living unit representative, treatment staff, and educational staff were involved in development of the plan. Each performance plan was signed by the youth, treatment team leader, and all parties with significant responsibility in goal completion.

Each of the performance plans addressed at least one of the top three criminogenic needs identified in the Residential-Positive Achievement Change Tool (R-PACT) and identified specific delinquency interventions. The plans contained measurable individualized goals based on their identified needs. Youth and staff responsibilities to accomplish goals and target dates of completion were found in each plan. Each record contained notification a copy of the plan was sent to the court within the required time frame including to the parent/guardian and juvenile probation officer (JPO). Five of five youth interviews reveled all youth participated in the development of the performance plan and had knowledge of their goals.

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 to provide for performance plan revisions. A review of five youth records revealed eleven performance plan revisions were completed. All eleven were completed due to the Residential Positive Achievement Change Tool (R-PACT) reassessment at ninety-day intervals. One applicable record contained a discharge/transition summary with accompanying Pre-Release Notification (PRN)

None of the revisions appeared to be as the result of youth's demonstrated lack of progress. Staff interviews revealed the program has had no instances of youth requiring a performance plan revision due to failure to perform or complete required goals and objectives.

The program maintains the wellness plans developed by the youth's treatment team and recreational therapist in a separate binder for all youth. A review of the wellness plans for the five selected-youth revealed the plans were individualized with three to four objectives. Two of the five wellness plans had objectives with target dates past due. One youth required two revisions and were completed two and six months late. The other youth required one revision

which was completed two months late. There was no documentation of the program taking action to revise the target dates of completion or reevaluate the youth objectives for either youth record.

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

The program has a policy and procedures to provide for performance summaries and transmittals. A review of five youth records revealed eleven performance summaries were completed and transmitted to the applicable parties including the court, juvenile probation officer (JPO), parent/guardian, and youth. All transmittals were completed within the ten-day time frame. Each summary contained the required elements including status on goals, overall treatment progress, academic status, behavior, level of motivation/readiness to change, interaction with peers and staff, overall adjustment to program, and significant positive and negative events. There was evidence youth were able to read and comment on the performance summery prior to distribution. One applicable summary included the justification for release. Each of the summaries were signed by all required parties including a comment from the youth. For the one applicable release summary, the original was sent to the JPO along with the Pre-Release Notification (PRN) within the time frame with a signed copy in the youth record. Five youth interviewed found all five received a copy of the performance summary.

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

The program has a policy and procedures to provide for parent/guardian involvement. A review of five youth records revealed the parent/guardian was contacted at various stages in the case management process. 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 notification to the parent/guardian for each treatment team meeting. Each formal treatment team documented the parent/guardian was contacted by phone and whether they participated.

Interviews with administrative staff revealed parents/guardians are encouraged and expected to participate in their child's treatment from their initial intake. Case management staff invite parents/guardians to participate in their child's treatment by phone calls and letters. Youth interviews confirmed the program encourages parent/guardians to participate in the case management process.

There were thirty-one formal treatment teams documented in the five reviewed records. The documentation indicated the parent/guardian consistently participated by telephone in twenty

treatment teams. In the remaining eleven, an attempt to contact the parent/guardian was documented. Observations of treatment team during the annual compliance review confirmed the program contacted the parent/guardian for each youth. Two of the parent/guardians answered the phone and participated. The other two parent/guardians were unavailable, and staff left a voice mail regarding the attempt.

2.13 Members of Treatment Team	Satisfactory Compliance
The team includes, at a minimum, the youth, representatives from the program's administration and residential living unit, education, and others responsible for providing or overseeing the provision of intervention and treatment services.	

The program has a policy and procedures to provide for members of the treatment team. Treatment team documentation for five reviewed records included signatures of participation consistently of the treatment team leader, youth, administrative representative, living unit representative, treatment staff, recreational therapist, educational staff, juvenile probation officer (JPO), and parent/guardian. In one applicable youth's case, the gang liaison attended the treatment team. All the required members of the treatment team were present during the review week except the recreational therapist. However, there was documentation in each treatment team for the five youth the recreational therapist provided an update of youth performance.

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

The program has a policy and procedures to provide for incorporation of other plans into the performance plan. A review of five youth records revealed each performance plan incorporated the wellness, the education, and the treatment plan into the performance plan.

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

The program has a policy and procedures to provide for formal and informal treatment teams. A review of five youth records revealed the program conducted a monthly formal treatment team for each youth. Documentation supported the parent/guardian, juvenile probation officer (JPO) and other pertinent parties were invited and encouraged to attend.

All formal treatment team review documentation included the youth name and date of review, meeting attendees from required disciplines; the youth, representatives from program administration and living unit, and others directly responsible for providing, or overseeing provision of, intervention and treatment services to the youth. Each formal treatment team

documentation included comments from treatment team members, education, and recreational therapist. Observation of formal treatment team confirmed all parties were present or supplied written information and summitted it prior to the treatment team meeting.

The program documented monthly informal reviews for each of the five selected youth. The informal reviews were consistently completed two weeks following the monthly formal treatment team review. Participants in the informal reviews consistently included the youth and case manager.

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

The program has a policy and procedures to provide for career education. The program is classified as a Type 2 career education program which was confirmed during the executive director interview. The lead educator interview confirmed career education including personal accountability skills and behaviors leading to appropriate work habits for employment and living standards. The program provided youth with 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), Home Builders Institute (HBI), and the Technology Club.

Three closed youth case management records were reviewed. All youth had completed an employment application, a résumé, had an appointment with career source upon release, appropriate documents for obtaining employment, and documentation to support the youth's parent/guardian and JPO was made aware of the vocational plan for the youth. Interviews with administrative staff revealed the program offers C-TECH, horticulture, food handling, and ready to work programming.

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

The program has a policy and procedures to provide for educational access. The program integrates education instruction into the daily schedule in such a way to ensure the integrity of required minimum instruction time of 250 days of instruction distributed over a twelve-month period with a minimum of twenty-five hours of instruction scheduled weekly.

A review of the logbook included the following days, April 1-12 and May 1-24 for a total of twenty-eight school days. The review revealed class started on or about on-time three of the twenty-eight days. Youth were late to class and missed a total of four hours and thirty-five minutes in the two reviewed weeks of April and six hours and fifteen minutes of class time in the four reviewed weeks of May. The missed minutes were in increments from ten minutes to one hour. Interviews with educational and program staff confirmed youth were seldom on time for the first-class period of the day.

Professional development days used for teacher planning are documented on the education program calendar. Youth receive credits for educational and training experience. A daily activity schedule from the program and education program schedule confirmed this. The development of academic clubs provide youth in the program with increased access to academic and personal success as well as normalizing the school experience. The continued addition and development of industry recognized vocational certifications and experiences further strengthens programming for the youth served by the program.

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

The program has a policy and procedures to provide for educational transition plan. The program's instructional staff and youth complete an education transition plan upon entry including provisions for continuation of education and/or employment. Three closed youth records were reviewed and confirmed the following key personnel related to transition were included in the development of the plan: youth, parent/guardian, education representative, post release staff, school district personnel responsible for providing guidance services, and a designee of the Districts' Management Information System. All plans reviewed a transition plan developed with specific plans for continuation of education and/or employment, services, and interventions, recommended educational placement for post release, specific monitoring responsibilities, a sample employment application, a résumé, valid Florida identification card, and appointment with local Career Source, and evidence the youth's case manager and parent/guardian were made aware of the 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 to provide for transitional planning. A review of three closed records revealed each youth had a transition conference at least sixty days prior to the targeted release date. All required persons were invited in advance to the conference. The conference consistently reviewed the transition activities on the youth's performance plan, identified target dates for completion and persons responsible for completion with one exception. Each of the three transition conferences identified items the parent/guardian was to provide; however, the dates the parents/guardians provided the information or item was not documented in the three records. Each of the three youth transition conferences identified goals

with completion dates following the conference but prior to discharge which had already been on the youth's performance plan and completed prior to the transition conference. Each of the three records contained a copy of the Community Re-Entry Team (CRT) meeting. Documentation confirmed program staff consistently participated in each youth's CRT.

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 to provide for exit portfolio. A review of three closed records confirmed the exit portfolio was discussed and initiated for the youth at the transition conference. Each portfolio contained a state issued identification card, copy of the youth's transition plan, calendar, social security card, birth certificate, certificate of completion, educational records, school transcripts, résumé, and completed sample job application.

The record contained documentation the education staff forwarded the exit portfolio to the receiving school district. Each of the three records documented the exit portfolio was provided to the youth upon release.

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 policy and procedures to provide for exit conferences. A review of three closed records confirmed the exit conference was conducted after the program notified the juvenile probation officer (JPO) of the release and at least fourteen days prior to release. There was documentation in the case record including the date, signatures, and summary of pending transition goals. Each of the exit conferences verified the transition activities established at the transition conference and finalized plans for the youth release. Most of the required parties participated in the exit conference. All thee youth records clearly identified the community re-entry team meeting separately from the transition and the exit conference.

Neither the parent/guardian or the JPO for one youth's exit staffing were available to participate in the conference; however, there was documentation each of them was invited.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA) who is employed full-time by the program and on-site at least forty hours a week. The DMHCA is available twenty-hour hours a day, seven days a week in the event of a mental health or substance abuse emergency. A review of their license found it to be current and active, with an expiration date of March 31, 2019. An interview with the DMHCA reflected they are responsible for ensuring the timely and accurate completion of the required assessments, evaluations, and treatment plans. In addition, the DMHCA ensures the treatment programming at the program complies with all requirements outlined in the program's contract. The program will utilize the regional clinical director, who is a licensed clinical social worker, or the DMHCA, who is an LMHC, from a sister facility in Tampa to provide coverage in the absence of the DMHCA for the program. A review of their licenses found both are current and active, and do not expire until March 31, 2021.

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

The program has one licensed clinician who is the designated mental health clinician authority (DMHCA) for the program. The DMHCA, who is a licensed mental health counselor (LMHC), provides oversight to all treatment services offered within the program. The program will utilize the regional clinical director, who is a licensed clinical social worker, or the DMHCA, who is an LMHC), from a sister facility in Tampa to provide coverage in the absence of the DMHCA for the program. The licenses for all these clinicians are current and active, with no restrictions. They all expire 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.	

The program has a written policy and procedures to ensure metal health and substance abuse staff have the appropriate credentials. The program has two non-licensed clinicians who provide services to youth in the program. One is scheduled from Tuesday through Saturday and the other works Sunday through Thursday. This allows the program to have the appropriate coverage to deliver Substance Abuse Treatment Overlay Services seven days a week. Each of the non-licensed mental clinicians hold a master's degree in a relevant field of study. The program was able to provide documentation of twenty hours on-the-job-training in assessing suicide risk, mental health crisis intervention and emergency mental health services for both clinicians. The reviewed documentation also validated the administration of five Assessments of Suicide Risk (ASR) or crisis assessments conducted in the physical presence of a licensed mental health professional, which allows them to conduct ASR and prepare them for the designated mental health clinician authority (DMHCA) approval. A review of direct supervision logs confirmed non-licensed mental health clinical staff also receive at least one hour on-site face-to-face direct supervision by the DMHCA each week they worked. All records reviewed confirmed the licensed mental health professional, with direct supervision authority, reviewed and signed all ASRs within ten calendar days of administration of the instrument by non-licensed mental health clinical staff.

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 written policy and procedures which explain their comprehensive screening process conducted on each youth at admission. A review of documentation confirmed they follow the procedures outlined in the policy. A clinician completes a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) on each youth as part of their admission process. The reviewed documentation in all five records confirmed this assessment was completed on the day of admission by a clinician and was entered into the Department's Juvenile Justice Information System (JJIS). Four of the reviewed MAYSI-2 instruments were conducted by a trained staff. The program could not provide documentation of training for a former clinician who was no longer employed in the program. Reviewed documentation also confirmed all available information was also reviewed to ensure they get a clear picture of the youth's history. When the MAYSI-2 indicated a need for further assessment, each youth was referred for further evaluation by a licensed clinician using the program's mental health services referral. None of the youth had a "hit" on the MAYSI-2 in the category for suicide ideation. Each of the youth still had an ASR completed the day of admission as part of the program's assessment process. Additionally, there was documentation to reflect a clinician reviews each youth's Pre-Disposition Report (PDR), their most recent Positive Achievement Change Tool (PACT), and any available psychiatric/psychological reports during the admission process. Due to the specialized services offered in the program, the clinician will also complete a Substance Abuse Subtle Screening Inventory (SASSI), the BECK Depression Inventory–II, and a

Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening to assist with the program's classification process and to help develop initial treatment plan goals. Interviews with the executive director and designated mental health clinician authority (DMHCA) confirmed the program's admission process.

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

The program has a written policy and procedures defining how they will complete a new Comprehensive Mental Health/Substance Abuse Evaluation. Each of the five-reviewed youth mental health records included a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) which indicated a need for further assessment upon entry to the program. All five had a new Comprehensive Mental Health/Substance Abuse Evaluation completed within thirty calendar days of admission. All were completed by a non-licensed clinician, and each had a review by a licensed clinician within ten days of completion. Each reviewed assessment included the methods of assessment, identifying information, screening procedures, presenting problem, family history, history of abuse/neglect/trauma, behavioral observations, physical health, developmental history, mental health, mental status exam, substance abuse history and treatment, social history, sexual history, vocational skills, independent living skills, strengths, needs, abilities, transitional planning, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, summary of clinical impressions, and treatment recommendations. The results of the Comprehensive Mental Health/Substance Abuse Evaluation are used to help develop each youth's individual treatment plan.

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.*	

Each youth is assigned to a treatment team on their day of admission. A review of their records found a description of the treatment team which was reviewed and signed on the day of admission by the youth and a licensed clinician. The review of treatment plan reviews confirmed the team consists of all required members. The mental health and substance abuse daily service progress notes for five youth were reviewed. The mental health treatment notes were documented on a form which contained all the information found on the Department's Group Progress Note form. This review confirmed all five of the youth received services as set forth in their individualized treatment plan, without any exceptions. Each of the five reviewed records contained a signed Youth Consent for Substance Abuse Treatment form, and a signed Youth Consent for Release of Substance Abuse Treatment Records form. A review of all five youth mental health and substance abuse daily service progress notes, as well as group sign-in sheets, validated substance abuse groups had no more than fifteen youth presents during any group sessions. During the annual compliance review, observations of a substance abuse treatment group also found there were no more than fifteen youth presents in the group.

An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides substance abuse treatment groups, family counseling, individual counseling, and psychosocial skills training. The DMHCA indicated substance abuse treatment groups are conducted seven days a week, individual counseling occurs no less than once a month for each youth, and family counseling is scheduled bi-monthly for each youth. All five interviewed youth indicated they attend group treatment. Five interviewed youth indicated they were each participating in group treatment. Five interviewed staff indicated they do not facilitate substance abuse groups. One indicated trained staff may facilitate Impact of Crime (IOC) and Thinking for a Change (T4C) groups.

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

Each of the five applicable youth records contained an initial treatment plan which was completed on the day of admission. All were completed on a form which contained all the elements of the Department's Initial Mental Health/Substance Abuse Treatment Plan sample form and were signed by all treatment team members. Each was also reviewed by the designated mental health clinician authority (DMHCA), within ten days of completion. All five records also contained an individualized treatment plan which was completed within thirty days of admission. Each plan was signed by the treatment team and reviewed by the DMHCA within the required ten-day time frame. These were completed on a form which had all required elements found on the Department's Individualized Mental Health/substance Abuse Treatment Plan sample form. Each of the youth had treatment plan reviews which were completed every thirty days, as required. Three closed records were reviewed for youth released from the program. There was evidence the program had completed a Mental Health/Substance Abuse Discharge Summary in each reviewed record. These plans were discussed and finalized at the exit conference for each youth. Reviewed documentation confirmed these plans were provided to the parent/guardian of each youth upon release. The mental health/substance abuse records, including the Mental Health/Substance Abuse Discharge Summary, were sent to the juvenile probation officer (JPO) within five days of each youth's release from the program. Additionally, a copy of the Mental Health/Substance Abuse Discharge Summary was emailed to each youth's assigned JPO on their date of discharge.

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's contract with the Department requires them to provide Substance Abuse Treatment Overlay Services (SAT overlay services). A review of five individual healthcare

records confirmed the program conducts urinalysis screening on each youth at admission, and they drug screen at least three youth randomly each month. The program provides individual, group, and family counseling to all youth within the program. Substance abuse groups are provided to all youth seven days a week. The designated mental health clinician authority (DMHCA) is on-site forty or more hours a week, at least five days a week, which meets the requirement of a facility operating under Chapter 397. Clinical staff are on-site seven days a week based on a staggered schedule. Individual and family counseling is offered by the therapists as designated in each youth's individualized treatment plan. Most of the family sessions are conducted by phone to ensure compliance with their plan requirements; however, family members are welcome to participate in person if they can make it to the program. The program utilizes a psychiatrist to provide medication management and address any other issues which may arise. The program's contract and SAT overlay service requirements indicate the psychiatrist must be on-site bi-weekly to provide services to the youth. Their agreement with the program states they will provide services on-site twice a month, and by telepsychiatry two times a month, which is currently no allowed by the Department. They are also available twenty-four hours a day, seven days a week. A review of psychiatric service logs found the psychiatrist is providing services through tele-psychiatric means at least twice a month for the review year, which is currently not allowed by the Department. Services are provided each week; however, the Department's Office of Health Services (OHS) indicates telepsychiatry is only allowed after completion of policy revision which must include provisions from the Florida Department of Health and the requirements of administrative Florida Administrative Rule 63N-1. Additionally, the program did not seek approval from the Office of Health Services (OHS). Youth with co-occurring mental health disorders receive mental health treatment through their individual sessions with their assigned therapist. The counselor-to-youth ratio does not exceed one-to-fifteen during group sessions, as confirmed through a review of group sign-in documentation. The therapist caseloads were found to be twelve and thirteen, respectively. When all beds are full, the caseloads for each of the non-licensed clinicians are fourteen youth each, which is within the acceptable range for youth receiving Substance Abuse Treatment Overlay Services.

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

The program has a contract with a licensed psychiatrist to provide psychiatric services, whose license is current and active, with an expiration date of January 31, 2020. The backup is another psychiatrist whose license is clear and active, with an expiration date of January 31, 2021. The program does not utilize an advanced registered nurse practitioner (ARNP). A review of five records revealed two of the youth were admitted on psychiatric medications. The program was able to provide one more applicable record for review. Program practice is for each youth, regardless of whether they require psychotropic medications, to be referred to the psychiatrist for an initial diagnostic psychiatric interview. The review of youth records confirmed each youth was seen by the psychiatrist in the correct time frame. Each initial psychiatric diagnostic interview was completed using the Department's Clinical Psychotropic Progress Note (CPPN) form, which contains all required elements. All three pages were used for each of these evaluations; however, none were specifically identified as an initial diagnostic psychiatric interview on the form. One of the youth in the sample was referred to the psychiatrist at a later date after admission. The youth was seen within thirty days of the referral, and had a psychiatric

evaluation completed by the psychiatrist using the CPPN. All required medication management appointments were completed monthly for each of the three applicable youth.
The program's contract and Substance Abuse Treatment Overlay Service requirements indicate the psychiatrist must be on-site bi-weekly to provide services to the youth. Their agreement with the program states they will provide services on-site twice a month, and via telepsychiatry two times a month, which is not allowed by the Department. They are also available twenty-four hours a day, seven days a week. A review of psychiatric service logs found the psychiatrist is providing services through tele-psychiatric means at least twice a month to include psychotropic medication reviews and initial diagnostic psychiatric interviews. Services are provided each week; however, the Department's Office of Health Services (OHS) indicates telepsychiatry is only allowed after completion of policy revision which must include provisions from the Florida Department of Health and the requirements of Florida Administrative Rule 63N-1. Additionally, the program did not seek approval from OHS. The psychiatrist did meet the requirements of their agreement with the program as written in the agreed upon contract, the review of logs also found lapses in meeting the bi-weekly visit requirement. There were two three-week lapses between on-site visits (December 18, 2018 through January 7, 2019 and January 21 through February 11, 2019) and one four-week lapse (April 15 through May 13, 2019). Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the psychiatrist validated she is on-site twice a month and provides telepsychiatry services the other alternating weeks. She indicated she communicates with the clinicians and provides input for treatment team either while on-site or through telephonic means. The psychiatrist indicated she has no concerns with the healthcare provided at the program.

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

The program has a written suicide prevention plan detailing the program's suicide prevention procedures. The plan outlines how the program will safely assess and protect youth with elevated risk of suicide in the least restrictive means possible. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, level of supervision, referrals, communication, notification, documentation, immediate staff response, and a review process. The plan was reviewed and signed by both the designated mental health clinician authority (DMHCA) and the executive director on January 23, 2019.

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

The program has a written policy and procedures in place outlining the methods used for supervising, observing, monitoring, and housing for youth identified through screenings, review of available information, or staff observations as having suicide risk factors. A review of five youth mental health and substance abuse records found each youth was screened with an Assessment of Suicide Risk (ASR) during their admission to the program. None of the five reviewed youth had a "hit" for suicide ideation on their MAYSI-2. It is the program's practice to conduct an ASR on each youth during the admission process, regardless of whether any suicide risk factors were identified. Each of the five youth, all of whom had no risk factors, were evaluated during admission, confirming the program's practice. Each of these youth had an ASR administered by a non-licensed clinician on the day of admission, and each were maintained on standard supervision. The program was able to provide documentation for three youth who were placed on precautionary observations after admission due to staff observations. Each of these youth had an ASR completed within twenty-four hours of them being identified as being at risk. The supervision for all three applicable youth was documented on a Suicide Precautions Observation Form. These forms were completed in their entirety, to include the identification of "safe housing areas." The review of each ASR reflected notification was made to the youth's parent/guardian and their assigned juvenile probation officer (JPO). Each youth was seen for a Follow-up Assessment of Suicide Risk (FASR) each day they were on precautionary observation until the decision was made to step them down to close supervision. Each youth was stepped down to close supervision through the completion of an FASR. The documentation also reflected a conference with a licensed clinician, when completed by a non-licensed clinician, and the executive director/designee prior to reducing the level of supervision. This was clearly documented on each reviewed form, and the DMHCA signed the form the next time they were on-site, when required. During these youth's heightened placement, their supervision was documented using Suicide Precaution Observation Logs and Close Supervision Logs. No lapses in supervision were seen on the reviewed logs. The youth were stepped down to standard supervision through the completion of an FASR. Each documentation reflecting the placement status of the youth was found in the master control logbook, and in the Department's Juvenile Justice Information System (JJIS) alerts. One exception was found in the reviewed logbook documentation. The logbook and FASR information indicated a youth had been stepped down to close supervision during the second shift at 4:00 p.m. The information recorded at the start of the next shift reflected the youth was still on constant supervision. The youth status was corrected at the beginning of the next shift. This error did not cause any supervision lapses based on a review of the close supervision logs. The program had no youth placed in secure observation during this review period. The program has a suicide response kit in the administrative area and in the medical clinic. Each kit was found to include a knife-for-life, wire cutters, and needle nose pliers. Interviews were conducted with five staff regarding what

they are responsible for if a youth expresses suicidal thoughts. All five indicated they will notify the program's clinical staff, three indicated they will document supervision on the youth, and one indicated they will contact emergency services. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, facility procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services.

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 review of five youth records found none of the youth had been placed on suicide precautions which required the completion of Suicide Precaution Observation Logs. The program was able to provide three applicable examples for review. There were seventeen logs available for review for these youth. All logs were maintained for the duration the youth was on suicide precautions, and the staff documented the youth's behavior in real time at intervals which did not exceed thirty minutes. Two of the logs were applicable for the documentation of warning signs. Each reflected warning signs being documented after notification being made to the designated mental health clinician authority and the executive director/designee. Each of the reviewed Suicide Precaution Observation Logs also had all required reviews by supervisory staff and licensed clinicians. Clear instructions were provided for staff regarding how each youth should be supervised. This was documented on the program's "Mental Health Alert Form." Additionally, the program prints their Suicide Precaution Observation Logs on yellow paper to make then stand out for staff. There was only one youth still in the program who had been placed on suicide precautions. An informal interview was conducted, and youth indicated staff were with them always during this placement, and they were never left alone while on suicide precautions.

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 in place which addresses suicide prevention training. A review of five staff pre-service and five in-service training records found each received at least six hours of suicide prevention training. The program's mock suicide drills were reviewed for the past year. This revealed the program conducts a mock drill quarterly, at least once on each shift. Each of the drills included the time of the drill, the designated shift, name of who conducted the drill, the nature of the incident, persons involved/function of each, type of medical of care given, type of mental health/crisis intervention provided, the outcome of the incident, the time of response, and any follow-up or corrective action needed. Also included were a management team review and critique, along with the date the drill information was shared with all staff at a monthly meeting. The review also found each drill had a sign-in sheet attached with the names and signatures of all staff who participated in the drill. A review of the sign-in documentation confirmed all staff participated in a mock suicide drill semi-annually.

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 comprehensive mental health crisis intervention services plan. The plan ensures the program responds 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 program. The plan includes a notification and alert system, means of referral including youth self-referral, communication, supervision, and documentation and review of the crisis. The plan was reviewed and signed by both the executive director and the designated mental health clinician authority (DMHCA) on January 23, 2019.

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

None of the five youth in the review sample had the need for a crisis assessment. The program had no youth during this reporting period who required the completion of a crisis assessment. They were able to provide a copy of the Department's Crisis Assessment form, which would be used if they had a youth in crisis. Additionally, the program has a comprehensive mental health crisis intervention services plan. The plan ensures the program responds 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 program.

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

The program has a detailed emergency care plan which addresses mental health and substance abuse emergency care. The emergency plan was reviewed and signed by both the designated mental health clinician authority (DMHCA) and the executive director on September 18, 2018. The plan contains all the required elements outlined in the Florida Administrative Rule 63N-1.0112 and includes the immediate staff response, notifications, communication,

supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, staff training, and they will review each incident.

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 had two Baker Act examples available for review. Documentation indicated one youth was identified during their monthly medication management meeting, and the other was identified during transport to the hospital for a medical issue. The youth who was in transport made verbal threats of self-harm, and Baker Act procedures were initiated by law enforcement who then transported the youth to the emergency mental health facility. The decision to send the other youth out was made by the psychiatrist. The youth was going to start a new medication and the psychiatrist was concerned about how the youth would react. The psychiatrist felt it would be best for the youth to receive this new medication in a setting where they would be safe in case they experienced certain side effects. The local sheriff was able to transport the youth to the emergency mental health facility. The program also sent a Request for Notification for each of these youth to ensure the program was notified when they were ready for release. Once each youth returned to the program, they were placed on precautionary observation until seen by a clinician for the completion of an Assessment of Suicide Risk (ASR). The reviewed information found each youth's level of supervision was stepped down according to the program policy and procedure. A Follow-up ASR was completed on each youth prior to their removal from close supervision. The documentation also reflected a conference with a licensed clinician and executive director/designee prior to reducing the level of supervision. An alert was entered into the Department's Juvenile Justice Information System (JJIS) for each of the applicable reviewed incidents. The program had no Marchman Acts during this annual compliance review period.

Standard 4: Health Services

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

The program has a policy and procedures which lay out the provisions and responsibilities of a designated health authority (DHA). The program entered into a contract with a licensed medical doctor to serve as the DHA. The DHA holds an unrestricted, clear, and active license, which expires January 31, 2020, to practice medicine in the State of Florida. The DHA has specialty training in internal medicine. There was documentation, in the form of sign-in sheets, to confirm the DHA is on-site weekly, for two hours. Furthermore, the reviewed documents confirmed the DHA was available twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and the coordination of off-site care. The program has a contract with a licensed doctor for coverage in place for scheduled absences, emergency services, and vacations. The backup doctor has an active license to practice in the State of Florida. The license expires January 31, 2021. The doctor has a specialty in internal medicine. The program does not utilize an advanced registered nurse practitioner or a physician's assistant. In an interview, the DHA verified the responsibilities for communication with the nursing staff regarding the youth's medical needs, and the availability by telephone for consultation, emergency care, and coordination for off-site care twenty-four hours a day. The DHA reported he had no concerns regarding the medical care provided to the youth.

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

The program has a policy and procedures to address health-related services provided to the youth. The program conducted an annual review of youth health-related services policies and procedures in January 2019. The policy and procedures were reviewed, approved, and signed by the designated health authority (DHA) and the executive director on January 23, 2019. Additionally, the DHA and executive director conducted an annual review of nursing protocols on January 23, 2019. After approval, the medical staff reviewed the program's health-related policies and procedures and the nursing protocols; their review was documented by a signature page. A review of the hire dates for the nursing staff documented there had not been any medical staff hired in the past six months. There were no blanket protocols. The policy related to psychiatric services was signed by the psychiatrist in January 2019.

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 to address parental consent, which requires notification to the youth's parents/guardians of any new medications, off-site referrals, and medical emergencies. Five healthcare records were reviewed. Three records contained a copy of a valid Authority for Evaluation and Treatment (AET); these AETs were valid until the youth's eighteenth birthday. One youth was eighteen years of age prior to admission to the program; he signed a release of information authorization form to allow sharing healthcare information with

his parent/guardian. In one record, there was a court order authorizing treatment; there was no documentation to support there was a dependency action in this case. The youth's mother moved out of state, therefore she placed the youth with his grandmother, however did not provide power of attorney to allow for consent of medical treatment. A court order was signed, allowing for routine medical treatment of the youth. There were copies of completed parental notifications in the records.

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

The program has a policy and procedures to address parental notification. The policy requires notification to the youth's parents/guardians of any new medications, off-site referrals, and medical emergencies. The policy requires additional informed consent for special circumstances such as hospitalizations, surgeries, or other invasive procedures. The program maintains a list of over-the-counter (OTC) medications approved by the designated health authority; the list is sent to all parent/guardians, with instructions to sign and return the form to the program, to provide their consent for the medications. Five healthcare records were reviewed. Each record contained documentation of parental notification for OTC medications beyond those covered by the Authority for Evaluation and Treatment (AET). Notifications were also sent, as needed, for the discontinuation of medication, the approval of OTCs beyond those covered by the AET, changes in condition/medication for youth with chronic conditions, non-routine dental procedures and for off-site medical treatment. For one youth, nursing staff stated the parent/guardian received verbal notification in addition to sending out a written consent to be signed and returned authorizing new medication. In one record, there was a court order authorizing treatment; there was no documentation to support there was a dependency action in this case. The youth's mother moved out of state, therefore she placed the youth with his grandmother; however, did not provide power of attorney to allow for consent of medical treatment. A court order was signed, allowing for routine medical treatment of the youth. All parental notices for this youth were sent to the judge. One youth was eighteen years of age at the time of his admission to the program; there were no parental notifications required; there were progress notes documenting the youth was advised of all treatment, and his consent of the treatment. All telephone calls and/or attempts were witnessed by a staff member.

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

The program has a policy and procedures to address the provision of psychotropic medications. The policy requires the third page of the Clinical Psychotropic Progress Note (CPPN) to be sent through certified mail to the youth's parent/guardian for the prescription of new psychotropic medications. The program is also required to attempt telephonic notice and consent prior to sending the CPPN. Five healthcare records were reviewed; three youth were prescribed psychotropic medications. One youth's record reflected verbal consent was obtained for the CPPN and there was documentation to support a staff member witnessed all telephone call attempts and conversations, and the youth's parent/guardian returned the signed forms. One youth was eighteen years of age at the time of admission; the CPPNs were provided to the youth directly. In one record, there was a court order authorizing treatment; there was no documentation to support there was a dependency action in this case. The youth's mother

moved out of state, therefore she placed the youth with his grandmother; however, did not provide power of attorney to allow for consent of medical treatment. A court order was signed, allowing for routine medical treatment of the youth. The CPPNs were sent to the judge, who signed and returned them to the program. There was no verbal consent for the medications for this youth. In all instances, medication was not given until proper consent was granted.

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

The program has a policy and procedures to address the verification of youth's immunization status. The policy requires the nurse to verify the youth's immunizations upon admission, update the information in the Department of Juvenile Justice Immunization Tracking record, and review the immunization record on the nursing chronological admission note. Five healthcare records were reviewed; each reflected vaccination was verified within thirty days of the youth's admission. Each record contained a copy of the youth's immunization record received from the Department, the Florida Shots website, and/or school records. There was no evidence of a youth's parent/guardian refusing to consent to a vaccination for medical reasons and/or any exemptions due to religious beliefs since the last annual compliance review. The nurse explained if a parent/guardian claims exemption and does not consent to vaccinations for religious reasons, the parent/guardian must file a waiver with the health department.

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

The program has a policy and procedures to address healthcare admission screening, which requires the completion of a Facility Entry Physical Health Screening (FEPHS). Five healthcare records were reviewed; each record contained a FEPHS form. Each FEPHS had been completed by a registered nurse, on the date of the youth's admission to the program. Additionally, the admission progress notes in each record documented the completion of the FEPHS.

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

The program has a policy and procedures to address the placement of youth on a medical alert system; the alert is to be placed on an internal alert and on the alert system on the Juvenile Justice Information System (JJIS). An alert is required for youth with chronic conditions, physical restrictions, allergies, and psychotropic medications. The program has an internal alert, which lists the youth's name, medical grade, allergies, restrictions, physical limitations, conditions, and medication side effects. In addition, there is a dry erase board in the administration area of the program, on which the youth's alerts are posted. The alert board utilizes a picture of each youth and color-coded pins which are stuck into the picture reflecting the current active alerts for each youth. The internal alert list is updated as needed by a nurse; alert status is updated on the alert board in master control when necessary. Five healthcare records were reviewed. Four youth

required placement on the internal alert and JJIS alert for seizure, allergies, temporary physical restrictions, and psychotropic medication. All alerts were entered and removed as required, with one exception; one youth was placed on physical restriction. The youth was allowed to resume regular activities on April 23, 2019; the JJIS alert was updated May 1, 2019. Alerts are discussed during each shift briefing.

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

The program has a written policy and procedures to address youth's orientation to healthcare services. The program's orientation covered all required topics including: how to access sick call, what constitutes an emergency, how medication is administered and possible side effects, the right to refuse care and how it is documented, and notifying staff of all allergies, chest pain, and/or extreme shortness of breath. The orientation also covers what to do in case of a sexual assault, and the non-disciplinary role provided by medical staff. Five healthcare records were reviewed; each record documented the youth received an orientation to the program's healthcare services on the day of admission to the program. The orientation was provided by a registered nurse. The orientation for each youth covered all the required topics. Each orientation form was signed by the youth, acknowledging receipt of the healthcare orientation.

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

The program has a policy and procedures to address the notification of the designated health authority (DHA). The policy requires notification of the DHA when a youth is admitted into the program with a known or suspected chronic condition, or if requiring emergency treatment. Five healthcare records were reviewed. Each record reflected telephonic notification to the DHA of the youth's admission into the program, regardless of the youth's medical condition. None of the youth were identified as needing an emergency response. The nurse was interviewed; she reported the DHA is notified of a youth's arrival at the program upon admission. The nurse completing the admission is responsible for the notification. Referrals to the DHA are documented on the Facility Entry Physical Health Screening (FEPHS) form.

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

The program has a policy and procedures which require healthcare admission re-screening to be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility. Five healthcare records were reviewed; none records were applicable for the youth being out of the program's custody. The program provided two applicable records for review. Both records reflected the registered nurse completed a new Facility Entry Physical Health Screening (FEPHS) form upon the youth's return to the program.

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

The program has a policy and procedures to address the completion of Health-Related History (HRH) upon admission to the program. Five healthcare records were reviewed; each record contained a new HRH. In all records, the HRH was completed by a registered nurse within seven days of the youth's admission to the program. All records documented the HRH was completed prior to the completion of the youth's Comprehensive Physical Assessment. There was clear documentation of the designated health authority reviewing each HRH.

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

The program has a policy and procedures which requires the completion of a new or updated Comprehensive Physical Assessment (CPA) prior to the youth participating in any strenuous activity. Five healthcare records were reviewed; each record contained a new CPA. In each record, the CPA was completed by the designated health authority (DHA) within seven calendar days of each youth's admission to the program. Each CPA documented the youth's medical grade and was completed in accordance with the Department's requirements. In all five records, the youth refused sections of the evaluation, therefore the Tanner stage could not be determined. Each CPA was signed by the youth to document their refusal. Reviewed documentation supported the Department's Problem List was updated for applicable youth, as required.

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

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

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

The program has a policy and procedures to address tuberculosis (TB) screening. The policy follows the Centers for Disease Control and Prevention recommendations, and the Occupational Safety and Health Administration Standards. Five healthcare records were reviewed; each confirmed the youth had received a tuberculin skin test (TST) within the past year. The TST results were documented on each youth's Comprehensive Physical Assessment and the Infectious Communicable Disease form. In each record, a Tier 1 TB screening was completed within seventy-two hours, prior to the youth's placement into general population. The Tier 1 screening was documented on each youth's Facility Entry Physical Health Screening. None of the youth presented signs to indicated further evaluation for tuberculosis was needed. Each youth's admission progress notes annotated the TST date, the date it was read, and the results of the test.

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

The program has a policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). Five healthcare records were reviewed; each youth self-identified as sexually active. Each youth was screened and referred to the designated health authority. There was further testing ordered for two youth, which was completed. The test was completed timely for one youth. For one youth, the test was ordered November 18, 2018 and was completed February 12, 2019. Each youth's test results were filed in the applicable youth's healthcare record, in the laboratory results section. The results were also documented on the Infectious and Communicable Disease (ICD) form in each youth's record. There were no youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present.

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

The program maintains a policy and procedures to ensure all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention and a referral for medical treatment. The program utilizes a community agency Metro Wellness, to provide pre-counseling, testing, and post-counseling. There were current 500/501 HIV training certification certificates facilitators. Five healthcare records were reviewed. All five youth consented in writing to be tested. The community agency provides education to the youth; during the education, the youth are asked who would like to be tested today. Due to this process, there was a delay for some youth to receive testing following their consent for the test due to them not wanting to be tested at the time they were asked. The program has a system in place to track youth who verbally refuse and encourage the youth to be tested while still in the program. Metro Wellness will not test a youth until they are ready to be tested. Three youth were tested in a timely manner; two youth were not. One youth signed the consent on November 16, 2018; the test was completed May 20, 2019. One youth signed the consent on August 29, 2018; the test was completed March 7, 2019. Each youth received pre-test and post-test post-counseling, which was documented on each youth's health education record. HIV test results were placed in a sealed envelope marked 'confidential' with the youth's name, program name and address, date of test, and youth's signature documented on the outside of the envelope; the enveloped were filed in the laboratory test section of the record. The program does not include HIV status as part of the internal alert system. Five youth were interviewed; all reported they could request an HIV test.

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

The program maintains a policy and procedures to ensure youth can make sick call requests and have their complaints treated appropriately through the program's sick call system. Sick calls are conducted seven days a week; at 9:30 a.m. and 2:00 p.m. During the facility tour, sick

call forms were observed in the multipurpose area. The youth alert staff and the staff will contact the nurse or designated health authority (DHA) of the pending request. During hours where no medical presence is at the facility, shift supervisors check the sick call box every two hours for immediate needs. If there is an emergent need, the DHA is contacted for guidance on how to proceed. The designated health authority (DHA) is on call twenty-four hours a day, seven days a week. Five healthcare records were reviewed; four youth submitted sick call requests for a total of seven sick call requests. None of the youth submitted a similar sick call request three times within a two-week period. There were two instances in which the youth complained of pain the staff was unfamiliar with; in both cases, they were treated as emergencies, resulting in an immediate referral to a licensed healthcare professional. The sick call request forms were filed with the chronological progress notes in the youth's healthcare record in reverse chronological order.

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

The program has a policy and procedures to address their sick call process. Five healthcare records were reviewed; four youth submitted sick call forms for a total of seven encounters. In all seven instances, the registered nurse (RN) addressed the youth's sick call request within twenty-four hours of submittal. The RN documented the youth's vital signs, treatment, education, and follow-up plans on the sick call request. Each sick call request was signed by the youth. Five of seven sick calls were documented on the youth's sick call index. All seven sick calls were documented on the program's sick call referral log. Six youth were interviewed; four youth indicated they could seek treatment within twenty-four hours and two indicated they have never requested a sick call.

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

This the program does not conduct room restrictions/controlled observations; therefore, this indicator rates as non-applicable.

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

The program has a policy and procedures to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff are to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. Five healthcare records were reviewed; three youth required episodic and/or first aid care. One episodic care response was handled by a non-healthcare staff and two were handled by the registered nurse for on-site care. The care provided by non-healthcare staff was documented on the report of on-site healthcare by non-healthcare staff form. All required information, including date/time of episodic care, nature of the complaint, findings of the person rendering care, treatment rendered, and the name and credentials of staff providing care was documented. The youth was seen by healthcare staff the following day. Two instances of episodic care were handled by a nurse; the treatment was

documented in the Subjective, Objective, Assessment and Plan (SOAP) elements. All three instances of episodic care were documented on the program's episodic log.

There are seven sealed first aid kits; three kits are located in master control, one in medical, one in the kitchen, one in the maintenance room, and one in the classroom. Items in the first aid kits have been approved by the designated health authority. Three first aid kits were observed; all required items were in each kit. None of the items were expired. The kits to be used in transports are maintained in master control. The facility has one automated external defibrillator (AED) which is located in the hallway of the multi-purpose room. The AED was noted to be operational. The batteries on the AED were installed on March 13, 2017; the batteries expire July 2022. The pads in the AED were installed on July 29, 2018; the pads will expire in August 2020.

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

The program has a policy and procedures to address emergency healthcare for the youth, which provides emergency medical, mental health and dental care to the youth twenty-four hours a day. The training records of ten staff were reviewed; each record contained documentation to support training in emergency care. All ten staff had current certification in first aid, cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED). There was one nurse at the program at the time of the annual compliance review; she had current first aid and CPR certification. There is a list of emergency telephone numbers, including poison control, posted in the medical clinic. The program conducted monthly medical drills on each shift. There were drill documentation sheets for monthly drills exceeding the quarterly requirement. The drill scenarios included head injury, sudden mental changes, chest pain, asthma attack, fracture, cardiac arrest, chocking, seizures, and arm injury. The drill documentation consistently included the time/date the drill stared and ended, the type of drill, the participants, persons notified, any identified deficiencies, and corrective action plan; each was signed by the nurse and the executive director. There was documentation in the form of staff meeting minutes to support the drills were reviewed monthly, to allow all staff to be aware of the procedures. There is one AED; located in the hallway adjacent to the day room. The AED is checked monthly by the registered nurse to ensure it remains charged and operable. The monthly checks were documented on an emergency equipment inspection log. During the annual compliance review, the AED was checked; the AED operating instructions were located in a binder, stored with the AED. The AED was noted to be operable. The batteries in the AED were installed in March 2017; the batteries will expire July 2022. The pads were installed July 2018; the pads will expire August 2020. The supervisory staff have been trained to assist youth in the use of an epinephrine auto injector, in the event the need arises, and a nurse is not on-site. Five staff were interviewed; all reported being able to call 9-1-1 in the event of an emergency.

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

The program has a policy and procedures to address emergency care for the youth, which includes the provision of off-site care. The policy includes notification requirements, as well as

requirements for the completion of the Summary of Off-Site Care form. Five healthcare records were reviewed. Three youth were taken off-site; each youth was taken off-site on two occasions. The youth were taken to the dentist, to the emergency room in response to a seizure, to a neurologist, and for hand and knee injury. There was a Summary of Off-Site Care form completed for each use of off-site care. The form and applicable discharge paperwork were filed in each applicable youth's healthcare record. There was parental notification for both instances of off-site care for two youth. One youth was noted to be in the custody of his grandparent, however the youth's mother was contacted regarding his seizure and subsequent trip to the emergency room. There is a court order for this youth, to allow for routine medical treatment; the judge received notice of the youth's off-site care and consented to the treatment and medication. Three instances of off-site care required follow-up care; this was documented as required in all applicable records. The designated health authority (DHA) reviewed each Summary of Off-Site Care form; this was documented by the DHA's initials, and the date of his review.

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

The program has a policy and procedure to address identifying and monitoring youth with a chronic illness. The policy requires youth with a chronic illness to receive regularly scheduled and as-needed treatment, to ensure proactive health program is developed. The admission healthcare process is completed by a nurse; chronic conditions are documented on the admission progress note in the youth's record and are verified with the youth's parent/guardian. All youth are placed on the list to be seen by the designated health authority (DHA) on the next scheduled visit to the program. When a youth is identified with a chronic medical condition, the nurse places the youth's name and condition on a tracker maintained on the nurse's computer. The nurse calculates ninety days from the date the youth was initially seen by the DHA and places the youth on the tracker for the periodic evaluation. The tracker also includes youth with medical needs which are not identified as chronic, however require the youth to be seen by the DHA, such as intake and follow-up appointments following off-site care. The youth who are taking psychotropic medications are placed on a separate list to be seen by the psychiatrist for medication management. Five healthcare records were reviewed; two youth were identified as having a chronic medical condition, including headaches, and gastroenterology issues. The program provided two additional records for review; the youth had been identified with acne and asthma. All four youth had been placed on the tracker for a periodic evaluation. The youth who was identified with chronic headaches, also had dental issues; upon the extraction of a tooth, the youth's headaches subsided, therefore he was removed from the tracker. None of the remaining three youth had been in the program long enough to have a periodic evaluation completed. The dates on the tracker for the applicable youth document appropriate dates for the youth to be seen by the DHA. One youth's problem list was updated when required. A treatment plan was developed for all four youth. Three youth were prescribed a psychotropic medication. There was documentation to support each youth was seen at least monthly by the psychiatrist for medication management. The DHA was interviewed; he reported periodic evaluations were conducted at three month intervals or less. He further reported the youth are tracked by the nurse to ensure this requirement is met. The DHA reported he meets weekly with the medical staff, either before or after clinic, to review medical issues pertaining to the youth. The program's executive director was interviewed; he reported each youth has a medical evaluation which is reviewed by the nurse prior to the youth's admission to the program. If there are any medical concerns, the nurse contacts the DHA for additional instructions.

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

The program has a policy and procedures to address medication verification requirements. The policy requires youth's medications to be administered by order of the consulting physician, designated health authority (DHA), or psychiatrist. The policy requires the medication to be verified; only licensed personnel are permitted to enter medication information on the youth's Medication Administration Record (MAR). The program only accepts medications from a licensed pharmacy, with a current, patient-specific label on the original medication container. Upon a youth's admission to the program, the healthcare admission process is initiated by the nurse; any medications the youth was admitted to the program with are documented, as well verification of the medication with the youth's parent/guardian. Five healthcare records were reviewed. Two youth were admitted to the program with prescription medications; the program provided an additional applicable record for review. All three youth had been transferred to the program from a Department of Juvenile Justice detention center therefore the medications were deemed to be verified. All medications were verified with the youth's parent/guardian by the nurse; this information was documented on the admission progress note in the youth's healthcare record. All records documented the designated health authority (DHA) were notified of the youth's admission; in three applicable records, the psychiatrist was notified of the youth's admission. There was documentation to support a verbal order to continue the medication for all applicable youth. One youth lived with his grandmother, as his mother was living out of state. A court order was sought, as it was reported the youth's mother would not sign a power of attorney to allow her mother to consent to treatment and the court order allowed for routine medical treatment for the youth.

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

The program has a policy and procedures to address medication management. The policy requires all medications to be given pursuant to a current prescription or physician order. Five healthcare records were reviewed; all youth were prescribed medication or were administered over-the-counter (OTC) medication at some point during their stay at the program. All medications were provided pursuant to a current, valid order. Any changes to medications were provided with a valid order. Four youth were provided OTC medications. The OTC medication for two youth were not listed on the Authorization for Evaluation and Treatment (AET); the medications were consistently provided in accordance with approved protocols. There was documentation to support each youth received the medication as prescribed.

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

The program has a policy and procedures to address the storage of medication and items defined as sharps, which includes a process for the destruction and disposal of applicable medications. The program disposes of controlled medication when the pharmacy consultant is

on-site; other types of medication are destroyed through a disposal bottle which eats the pills. All medication and sharps are securely stored in the medical clinic. A locked medication cart containing prescription medication for the youth and a working supply of over-the-counter (OTC) medications is located in the locked clinic. The medication cart has separate drawers in which various types of medications, such as topical, oral, and injectable, are stored. The narcotics and controlled medications are stored on the medication cart behind two separate locks. The bulk OTC medications and sharps are stored in a locked cabinet in the clinic; all of these items are inaccessible to youth. There is a locked refrigerator in the clinic to be used for medical purposes. During the annual compliance review, the contents of the refrigerator were observed; there were medical supplies and a jug of water in the refrigerator. There was documentation of the destruction of controlled medication during the pharmacy consultant's monthly visit to the program.

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

The program has a policy and procedures to address the storage of medication and items defined as sharps, which includes the procedure to be used in the event any discrepancies in the counts of medications and sharps are noted. All prescriptions medications, over-the-counter (OTC) medications, syringes and sharps are securely maintained in the clinic. The patient-specific prescription medications and a working supply of OTC medications are on the locked medication cart, which is maintained in the clinic. All prescription medications received from the pharmacy were on cardboard cards, with each pill in a bubble pack. Each pill was numbered, allowing for a more accurate accounting of the medications. The program's nursing staff completed weekly and perpetual counts of the sharps and the OTC medications; the inventories were completed consistently for the past six months, with no discrepancies noted. During the annual compliance review, the counts of three sharps (staple removal, suture removal kits and butterfly syringes) were matched against the current inventory; all counts matched the inventory. Three bulk OTC medications (saline wound wash, dandruff shampoo and allergy medication) were counted; the counts of all three items matched the current inventory. Three open OTC medications (pain reliever, triple antibiotic ointment, and antacid) were matched against the current inventory; all counts matched the inventory. Three prescription medications were counted; all matched the current count of the medication. Five healthcare records were reviewed; each youth had received either a prescription medication or an OTC medication during their stay in the program. The Medication Administration Record (MAR) for each youth documented the youth received each medication as ordered. There were no lapses or discrepancies noted.

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

The program has a policy and procedures to address the management of controlled medications; the policy includes a procedure for conducting shift-to-shift counts, which requires discontinued medications to be counted until disposed. All controlled medications are maintained in a separate locked compartment of the locked medication cart. The controlled medications are delivered from the pharmacy on cardboard cards. Each pill is in a bubble pack, with each pill numbered, to allow for a more accurate accounting of the medications. The nurse

completes a count of the medications at the beginning of each shift. For two months prior to the annual compliance review, there has only been one nurse at the program. The shift-to-shift counts of controlled medications are completed by the nurse and a supervisory staff. This process was not observed during the annual compliance review. At the time of the annual compliance review, one youth was taking a controlled medication daily. In addition, one youth had recently had a seizure. The youth had been prescribed a controlled medication to be used in the event he had another seizure; there was one pill in the prescription. The program documented perpetual counts of the medications on the both youth's Controlled Medication Inventory Record. There were shift-to-shift counts of each controlled medication documented on the applicable youth's Controlled Medication Inventory Record.

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

The program has a policy and procedures to address medication administration; the policy requires only licensed staff to enter prescription information on the Medication Administration Records (MAR). The program utilizes pre-printed MARs from a pharmacy. Each youth's MAR for the current month are maintained in a binder, which is maintained in the clinic. There is a picture of each youth with the active MAR. The MARs from previous months are placed in each youth's healthcare record. Five healthcare records were reviewed; each record contained the MARs from previous months. Each youth received either a prescription or over-the-counter (OTC) medication while in the program. Each administration of medication was documented on the applicable youth's MAR. All reviewed MARs contained the youth's name, DJJ identification number, date of birth, allergies, side effects, medical grade, precautions, and medical alerts. The information, including the stop and start dates of each medication were documented by a nurse. The MARs also documented when medications were discontinued. Two youth entered the program taking medication; the program provided one additional applicable record for review. Each applicable MAR documented the youth received their medications as ordered prior to their placement into the program. The nurses consistently documented weekly monitoring for side effects on the MARs. The MARs documented each youth received medications as ordered, with no missed doses noted. The staff and youth initialed all dosages of medication. Any refusals of medications were noted as required.

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

The program has a written policy and procedures regarding their medication administration process. The program has two nurse positions; at the time of the annual compliance review, one position had been vacant for two months. The youth's medications are administered to the youth by the nurse when she is on-site. There were no youth requiring the administration of parenteral medications. The medication administration process by a registered nurse was observed for six youth during the annual compliance review; each youth provided verbal consent for this observation. The medication administration occurs in the hallway between the dayroom and the living area. During the medication administration time, all youth were required to sit quietly in dayroom. Each youth taking a medication was escorted to the medication cart by a direct care staff. The nurse stood on one side of the cart, to maintain control of the medication. The nurse's

sole responsibility was to provide the medication, as the direct care staff provided supervision of the youth. As each youth approached the cart, he said his name, the medication he was taking, and a side effect of the medication. The nurse poured a cup of water as each youth walked to the cart. The nurse consulted the youth's MAR, retrieved the correct medication, and placed the medication in a small paper container. Each youth was provided a cup of water and the medication. There was no pre-poured medication. One youth was prescribed a medicated face creme; the youth was escorted to the restroom by staff to apply the crème. After each youth swallowed the medication, the nurse had the youth cough and open their mouth to ensure the youth swallowed the medication. The nurse and each youth initialed the Medication Administration Record. The youth were familiar with the process and appeared to be comfortable with it. Six staff were interviewed; all staff reported medications are administered by nurses. Five staff reported supervisors administer medications. Six youth were interviewed; five youth reported receiving medication from a nurse; the youth were able to describe the medication process. One youth reported he did not take medication.

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

The program has a written policy and procedures regarding the medication administration process, allowing for trained, supervisory staff to assist youth with medication administration. At the time of the annual compliance review, there was only one nurse at the program; the second nurse position had been vacant for two months. Five healthcare records were reviewed; three youth had received medication from non-licensed staff. All medication administration was initialed by the youth and the staff on the youth's Medication Administration Record. There was documentation to support the staff had been trained by the nurse to assist youth in medication administration. The medication, which was oral, topical or inhaler, was provided by non-healthcare staff at times when the nurse was not on-site. The medication administration by non-licensed staff was not observed during the annual compliance review. Six staff were interviewed and all reported medications are administered by nurses. Five staff reported supervisors administer medications. Six youth were interviewed and all youth reported receiving medication from a nurse; the youth were able to describe the medication process. One youth reported he did not take medication.

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

The program has a written policy and procedures to address monitoring of youth taking psychotropic medications. The procedures did not include standing orders or as needed orders (PRN) for psychotropic medications nor for the provision of emergency treatment orders for psychotropic medications. The program contracts with a psychiatrist to provide on-site psychiatric services for the youth. The psychiatrist's license is clear and active to practice in the State of Florida; the psychiatrist's license expires January 31, 2021. The psychiatrist completes psychiatric evaluations on all youth, and psychotropic medication management for applicable youth. The program provides notification to the designated health authority (DHA) for all youth

upon admission to the program, regardless of the youth's medical condition. For youth taking psychotropic medication upon admission, the DHA and the psychiatrist are notified. The psychiatrist determines whether the medication should be continued until an evaluation can be completed. Five healthcare records were reviewed; one youth entered the program with psychotropic medication. The program provided one additional applicable record for review. The DHA and psychiatrist had been notified upon each youth's admission to the program. The psychotropic medication was ordered to be continued for both youth. There was a psychiatric evaluation completed for both applicable youth within fourteen days of their admission to the program. A psychiatric referral was required for three youth; the psychiatrist was contacted within twenty-four hours for each youth. The psychiatrist determined psychotropic medication was needed for two youth; an initial diagnostic psychiatric interview was completed within fourteen days of the start of the medication. Each evaluation contained all required information. The evaluations were consistently signed by the psychiatrist; the signatures were dated. The psychiatrist used the Clinical Psychotropic Progress Note (CPPN) to document the psychiatric evaluation and the medication management. The CPPNs did not document whether monitoring for Tardive Dyskinesia was required. For youth who required this monitoring, it was completed monthly. The program utilized a psychotropic medication monitoring tool, to documents whether youth are displaying side effects such as sleepiness, depression, tremors, chest pains, dizziness, dry mouth, anxiousness, increased or decreased appetite and rashes. The form was completed monthly for youth taking psychotropic medications. One youth was living with his grandparent, as his mother resided out of state. There was a court order allowing for routine medical treatment for the youth, as the youth's mother did not provide power of attorney to allow her mother to consent to treatment. When the youth needed to be placed on psychotropic medication, the program sent the CPPN to a judge; the CPPN was signed by the judge and returned to the program. Each time the youth's medication was changed, the CPPN was sent to the judge for signature. The youth's mother remained active in the youth's treatment, as she was involved in family counseling, and was contacted when the youth had a seizure. The program reported the process of sending notification and receiving consent from the judge was continued, as it was easier to contact the judge than the mother.

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

The program has a policy and procedures to address infection control. All required elements, including: common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, hepatitis A, B and C, Human Immunodeficiency Virus (HIV), infectious diseases, other outbreaks or epidemics caused by any other infectious agent, outbreaks of pediculosis, and/or scabies, methicillin-resistant staphylococcus aureus (MRSA), food-borne illnesses, bio-terrorist agents and chemical exposure in the workplace were included in the plan. The plan addresses requirements for staff training, hepatitis B vaccination and post-exposure follow-up. The infection control plan was signed by the designated health authority (DHA) and the executive director on January 23, 2019. During employee orientation, staff receive information regarding hepatitis B immunizations; if the staff consents to the immunization, further information is provided to the staff. There have been no reportable incidents to the local county health department and/or Centers for Disease Control since the last annual compliance review. There are spill kits, and

personal protective equipment such as bio-hazard bags, gloves, gowns, and masks available to the staff.

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

The program has an infection control plan contains, which includes requirements for the provision of infection control training for staff and youth. The healthcare records of five youth were reviewed; there was documentation in each record to support the youth received infection control education. Each Health Education Record documented the training was provided on the day of the youth's admission to the program. The training included the prevention of communicable diseases and the prevention of blood-borne pathogens. The training records of ten staff were reviewed. There was documentation in each record to support receipt training on the program's exposure control/infection control plan and blood borne pathogens. The training, which was facilitated by the program's registered nurse, was provided annually as in-service, and as part of the program's pre-service training.

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

The program has a combined infection control and exposure control plan. The plan includes all required elements and is available for the staff in the clinic. The exposure control plan was signed by the designated health authority (DHA) and the executive director on January 23, 2019. There was training on the program's exposure control plan provided annually by the program's registered nurse. There is a copy of the infection control and exposure control plan in in master control and in the clinic, to allow for easy access when needed. The executive director was interviewed; he reported the exposure control plan is located in the clinic and in master control. He further reported the exposure plan is reviewed with staff during their orientation and on an annual basis.

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

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

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

lactation.

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

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures for active supervision of youth. The program has a full schedule of activities posted in the common area which staff follow and ensure positive interactions between youth and staff. A review of the logbook revealed the program substantially followed the posted schedule. Staff were observed posted in appropriate positioning and engaged in positive conversations with youth and providing respectful feedback and redirection when needed. Staff were observed during various scheduled activities such as meals, class, groups, and recreation. Several staff were questioned regarding the number of youths for which they were supervising, each staff responded with the accurate number of youth and did not have to count the youth before responding to the question. Five interviewed staff were able to explain what the procedures were if they cannot reconcile the count and understood the youth ratio requirements.

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

The program has a policy and procedures to address the behavior management system (BMS). The BMS is reviewed with the youth during orientation and is also included in the resident handbook, as well as posted in the common area. A detailed written overview of the BMS was seen in youth orientation documentation which stresses the use of natural consequences the BMS includes a variety of rewards and incentives to encourage youth. 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 points are based on adhering to rules, participating in school and groups, keeping their room clean, maintaining a good attitude, following the schedule, participation in daily activities, and developing appropriate behaviors with others. Five staff were interviewed indicated an understanding of the BMS. Ten of ten staff training records reflect they have received BMS training. Five of five youth interviewed indicate they understand the BMS, and the difference between each level and how they move from level to level. Five youth interviews also reflect youth are familiar with type of rewards and incentives. The executive director interview indicates the BMS is a four-phase system which addresses seven thinking patterns associated with youth thinking. Each phase is set for six weeks when youth earn their applicable amount of points. The executive director stated rewards are monitored weekly during management team meetings which ensures staff are scoring youth behavior correctly and if any adjustments need to be made and includes an education representative

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

The program has a written description of the behavioral management system (BMS) which explains the process for staff and youth to talk about consequences and alternate behaviors they could use. The BMS does not allow youth to be locked in rooms or the use of room restriction, youth to discipline youth or group punishment. Observations during the week indicated there are no youth being secured behind locked doors or in rooms. It is noted the youth rooms do not have doors on them. 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. Five staff interviews indicated supervisors provide feedback on the implementation of the BMS, and youth are informed of the consequences and/or can explain their behavior. The executive director interview stated consequences are monitored through treatment team and emergency team meetings, he also indicated all staff members are trained in the implementation of the BMS with follow up discussions with staff during their ninety-day evaluation and annual evaluation. A review of three job descriptions reflect the required qualifications of staff whose job functions includes implementation of the BMS.

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

The program has a policy and procedures to address visual observation of youth when they are placed in their rooms for sleeping purposes. The policy requires staff to conduct room checks every ten minutes or less. Ten-minute checks are documented electronically by means of the Guard One Touch System. A review of ten-minute checks on video coverage for various days, times, and shifts show staff observe youth in rooms which did not exceed ten minutes, and were documented in real time. A review of twelve electronic ten-minute checks revealed checks were documented and a review of the hard copy of electronic checks revealed there were missing checks; however, after further examination there was in fact completed ten-minute checks. It was discovered the missing checks were due to a malfunction with the wall chit using the Guard One Touch System wand. This was fixed the same day and the team was able to verify the ten-minute checks were being accounted for in the system with no missing checks. Five staff

interviewed indicate room checks are conducted between eight and ten minutes when youth are in their rooms for sleeping purposes.

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

The program has a policy and procedures addressing youth census, count, and tracking. The main facility count is maintained on a dry erase board located in the staff area just outside the executive director's office and in the master control log book. A review of the facility logbook indicated headcounts are done at the beginning of each shift and at the end of each shift, after emergencies, and after outside activities. Scheduled counts are conducted every hour and documented in the master control logbook. Informal counts occur after every movement to and from class, group, codes, and meals. Facility logbooks includes youth movements, daily census counts and any change in count to include admissions, releases, transports, and transfers. Youth census and tracking is maintained through the facility logbooks. Observation of youth counts indicated staff followed the process in verifying accurate count during the annual compliance review. Five staff interviews 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. Facility logbooks are bound with numbered pages. Entries are legible, include time of event, names of staff, and youth involved, a brief description of the event, the name and signature of the person making the entry. Documentation of youth movement, intakes, releases, transfers, activities, and schedule compliance could be found being entered by date and time and the names of staff and youth involved. All entries were legible. The program maintains one logbook is primarily kept by the shift supervisor during each shift. The logbook is available for all staff to review at any time. There were no entries removed; errors were struck through with a single line and initialed by the person correcting the error. All incoming staff signs and dates the log book indicating they reviewed the previous shifts information. Facility logbook was reviewed for eight Central

Communications Center (CCC) incidents and all eight were found in facility logbook, there were no Florida Abuse Hotline calls made during the past six months of the review period.

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

The program has a policy and procedures in place to govern the control and use of keys which includes key assignment/usage, inventory and tracking of keys, and secure storage of keys not in use. The procedures also include addressing missing or lost keys and reporting and replacement of damaged keys. All facility keys are placed on a tamper resistant key rings with a identifying tag, and the appropriate number of keys assigned to each ring sketched on the tag. A team member observed the following key rings were clearly labeled and secured in master control in a locked box: restricted keys, visitor keys, permanent keys, medical and unused keys. An interview with master control staff confirmed a key control log is used to maintain the key control process. During the annual compliance review, a team member conducted a sample check of staff keys and confirmed the facility operating procedures (FOP) for distribution and security of keys, was followed. The master control operator indicated there were no reports of lost or missing keys in the past six months. The master control operator also confirmed the restricted keys are as follows: the nurse is the only staff with access to the medical locked box with keys to youth medical secured records and mental health is accessible to mental health staff only. All youth records are stored in a locked cabinet in the director's office, where only the director has a key. According to the master control operator, the process for daily tracking and reconciliation of keys is the key control log. A review of the key control log for the past six months showed there were seven instances where the key log was missing the key tag number assignment to staff and there were seventeen instances where the key log was missing the sign-out time for keys received. Five staff were interviewed and confirmed master control operator's statements about the facility's key control process, replacing lost or damaged keys, and confirmed youth do not have access to facility keys.

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

The program has a policy and procedures addressing prevention of introduction of contraband. The program identified what is considered contraband in the employee handbook which includes consequences if staff are found with contraband. There is a contraband list posted in the lobby for staff and visitors. It identifies what is considered contraband. Daily and weekly contraband searches are documented in the facility logbook and on contraband search forms which includes the youth rooms, the facility, grounds, and recreation field. The executive director interview indicated the discovery of illegal contraband would be turned over to law enforcement. If not illegal it could be disposed of, sent to parent/guardian, or given to youth upon discharge from program. Notifications would be made to the management team, to include the executive director and assistant executive director. A review of logbooks contraband search forms and incident reports found no instances of contraband being found which required reporting to the local law enforcement. A review of contraband search form found items such as pens, pencils, shirts, undergarments, pillows, and towels.

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

The program has a policy and procedures to address searches. The policy requires youth to be searched by same gender staff as the youth. Full body visual searches are conducted during the admission process and when youth return from any off-site activities. Electronic hand-held metal detector is often used to search visitors. A team member observed youth being searched during the annual compliance review which revealed staff were thorough and provided instruction to youth politely. Searches were conducted by staff who were of same gender as the youth. Full body visual searches were not observed during this review due to the program not having an admission or a youth returning from off-site activity. Five staff were interviewed and indicated all searches are done 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
All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment, so they may be operated in a safe manner. *The program ensures any vehicle used by the program to transport youth is properly maintained, and maintains documentation on the use and maintenance of each vehicle. Each vehicle being used for transport of youth shall pass an annual safety inspection. Each vehicle used to transport youth is equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and an approved first aid kit. Youth and staff wear seat belts during transportation, and youth are not attached to any part of the vehicle by any means other than proper use of a seat belt.*	

The program has a policy and procedures to address vehicles and maintenance. The program has two vehicles used for youth transport. Both vehicles are equipped with a seat belt cutter, window punch, fire extinguisher, and a first aid kit. First aid kits are stored in facility until needed for transport. Vehicle invoices from a local automotive shop indicate vehicles are inspected annually and deficiencies were corrected. Transport vehicles are equipped with appropriate number of seat belts. The program did not have any transports scheduled during review period; however, the team member conducted an informal interview with staff and youth which 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.

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

The program has a policy and procedures to address the transportation of youth. The program ensures all transport drivers have a current driver's license. All five staff interviews indicate program cellular phone is provided for communication during all transports and personal vehicle are not used to transport youth. A random check of parking lot revealed vehicles were locked when not in use. Program provides at least two staff when transporting youth.
Rear and side cargo doors of two transport vehicles cannot be opened from the inside. Interview with staff and youth confirmed seat belts are worn by all youth and staff during transportation, youth are not permitted to drive, and staff do not leave youth unsupervised in a vehicle.

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

The program has a policy and procedures outlining the inspection process, which includes who is responsible for completing weekly security audits and corrective action when needed. An interview with the executive director indicate there is a clear process regarding the identification, tracking, deficiencies are addressed. Safety and security audits were completed and documented weekly.

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

The program has a policy and procedures in place to ensure youth do not use tools or equipment as weapons or security breaches. A team member observed the tool shed and office, which is located behind the kitchen, outside on the property and was found locked and secured. There were no prohibited tools observed during the tool shed and tool office inspection. Class "A" tools were maintained in a locked room outside of the kitchen area; inaccessible to youth. In addition, all class "A" tools are marked with the corresponding inventory number. All class "A" tools are labeled on a shadow board outlining their location. Each of the tools were indicated on the inventory sheets which were accurate and current. Five youth were interviewed and indicated they only use 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 also 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.	

The program has a policy and procedures in place to ensure guidelines are established to govern outside contractors, which include information about tool control and restrictions. A review of the visitor sign-in logs for the past six months (December 1, 2018 to June 1, 2019) indicated there was a total of eighteen vendors, of which sixteen were paid vendors and the other two vendors (barbers) donated their time and supplies. A random sample of seven invoices were selected and found all invoice dates of service matched the visitor sign-in and out log and a list all tools and supplies brought into the program.

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

The program has a policy and procedures in place to 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. A review of the fire, safety, evacuation, and disaster drill logs for the past twelve months (June 4, 2018 to June 4, 2019) 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 facility.

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

The program has a coordinated Continuity of Operations Plan (COOP). The plan and all plan annexes were in compliance with the Department of Juvenile Justice (DJJ) requirements. The plan was submitted by the program and reviewed by the regional director on March 22, 3019 and signed by the DJJ representative on March 26, 2019. The executive director confirmed the COOP is posted in master control and accessible to all staff. Five staff were interviewed and confirmed the staff participates in fire, safety, and evacuation drills monthly.

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 facility 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 has a policy and procedures in place to ensure strict control over flammable, poisonous, toxic items and materials and youth do not have access nor permitted to use, handle or clean with dangerous chemicals, biohazardous materials, fluids, or human waste. Five youth and five staff were interviewed and confirmed youth are not permitted to handle hazardous cleaning items.

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

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

The program has a policy and procedures to address recreation and leisure activities. The program's activity schedule is posted in youth common area and includes a range of supervised and structured indoor/outdoor recreation and leisure activities for youth. A review of the program's logbook reflect youth participate in recreation and leisure activities. Five youth were interviewed and reflect youth are provided various recreation and leisure activities for at least an hour each day. One of the five youth interviews indicate going outside depends on weather and if there is this particular supervisor on duty does not let us out no matter what the weather is like. Recreation was observed with staff encouraging youth to participate in the activities. Staff indicated if needed they would pause activity to keep youth hydrated and prevent overexertion. The program has a recreation therapist who meets all of the qualifications and ensures therapeutic activity is incorporated into the youths' performance plan based on the developmental level and needs of the youth. Five staff were interviewed and indicated youth are provided a variety of recreation and leisure activities for at least an hour each day.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures for visitation and communication with family members. During the admission and orientation process, youth are provided information regarding visitation, telephone calls, and communication through incoming and outgoing mail. The program maintains an approved visitor and phone log for each youth and is kept in a binder. Both parent/guardian and youth are provided handbooks outlining ongoing communication. The program holds visitation every Saturday from 1:00 p.m. to 4:00 p.m. and every Wednesday from 6:00 p.m. to 8:00 p.m. All telephone calls are recorded in the youth's telephone log with the number, time the call started and ended, and person called. Five youth were interviewed, and all stated they are allowed to send mail, make telephone calls, and participate in visitation.

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

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

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

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

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

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

Program Name: Charles Britt Academy
Provider Name: Sequel Youth and Families Services
Location: Pinellas County/Circuit 6
Review Date(s): June 4-7, 2019

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.17 Educational Access	3.09 Psychiatric Services*