STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Columbus Youth Academy

Sequel Youth and Family Services, LLC
(Contract Provider)
9502 East Columbus Drive
Tampa, Florida 33619

Review Date(s): December 10-13, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Jonathan Thompson, Office of Program Accountability, Lead Reviewer (Standard 1)
Marvin Bliss, Office of Program Accountability, Lead Reviewer (Standard 5)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 4)
Felicia Goldstein, Office of Program Accountability, Regional Monitor (Standard 3)
Peter Keelan, Office of Education, Education Coordinator (Indicators: 2.16, 2.17, 2.18)
John Mannion, TrueCore, Regional Compliance Manager, Peer Reviewer (Standard 2)

Program Name: Columbus Youth Academy
Provider Name: Sequel Youth and Family Services, LLC
Location: Hillsborough County / Circuit 13
Review Date(s): December 10-13, 2019

MQI Program Code: 1442
Contract Number: 10476
Number of Beds: 50
Lead Reviewer Code: 176

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

Overall Rating Summary

Limited Ratings	Failed Ratings
2.04 Classification Factors, Procedures, and Reassessment for Activities	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Columbus Youth Academy is a fifty-bed program, for thirteen to eighteen year old males, located in Hillsborough County, Florida. The program is operated by Sequel Youth and Family Services, LLC., through a contract with the Department. The program provides sexual offender treatment services. In addition, the program fosters each youth by providing Thinking for a Change, Impact of Crime, Young Men's Work, Coping with Stress: A cognitive behavioral therapy group for teens with trauma, Pathways, Skillstreaming, Life Skills Training, The Adolescent Doping with Depression, Passport, and Living in Balance. Additional treatment services provided includes individualized therapy, family therapy, recreational, and group therapy. Program administration is comprised of a program director, assistant program director, designated mental health clinician authority, director of case management, health services administrator, business manager, and a community liaison. Case management services are provided by the director of case manager, four case managers, and two transitional services managers. Mental health staff at the program includes the clinical director, assistant clinical director, and five licensed juvenile sex offender therapists. Medical services are offered daily from 7:00 a.m. to 5:30 p.m. by a licensed nurse and are provided by the health services administrator which is a registered nurse, a full-time registered nurse, a part-time registered nurse, and a full-time medical clerk. The program has a third RN who just accepted an offer and is pending the start of training. A copy of all licenses for clinical staff were reviewed and verified to be clear and active in the State of Florida. Expiration dates of both nurses are July 31, 2020 and April 30, 2021, respectively. Educational services are provided by the Hillsborough County School Board. The layout of the program includes one large facility, which consists of three youth dormitories, three classrooms, kitchen, master control area, two group rooms, a game room, administrative offices, and recreation area. The program has thirty-eight operating security cameras providing coverage. At the time of the annual compliance review, the program had three vacant positions; one master control officer, and two youth care workers.

Strengths and Innovative Approaches

- Columbus Youth Academy completes community service projects such as working with local organizations including Women Helping Others to provide meals and care packages to the less fortunate, working with Feeding Tampa Bay warehouses to help sort and pack grocery items for families in need, as well as the Lighthouse Ministries where youth learn the importance of giving back to those who are less fortunate.

- Columbus Youth Academy offers youth unique programming opportunities which also enhance life skills such as crocheting, garden club, animal therapy, and yoga.

- Columbus Youth Academy has an active mentoring program including guest speakers. Recently the youth attended an invitation to attend "Coaches Mentoring Through Basketball" and had speakers like former WWE wrestler Ted DiBiase (The Million Dollar Man) and NFL Hall of Famer Warren Sapp come to the program.

- Columbus Youth Academy offers a finance group facilitated by a therapist, which gives youth the knowledge of the intricacies related to financing, credit, checking, and saving accounts.

Standard 1: Management Accountability

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

The program maintains a policy and procedures to address required background screenings upon hire. A review of the program's staff roster indicated the program hired ten new employees since the last annual compliance review on April 26, 2019. The ten new employees were queried in the Florida Agency for Health Care Administration website and revealed all ten employees received an eligible rating prior to working with youth. Additionally, a review of the ten new employee records verified a pre-employment assessment tool was administered and included a passing score for each newly hired employee . There were nineteen volunteers used by the program since April 26, 2019. The review confirmed each volunteer received an eligible background screening prior to working with the youth at the program. All program staff and volunteers were included on the Department's Background Screening Unit (BSU)/Clearinghouse employee roster. Reviewed documentation confirmed the hiring authority reviewed the status of the Department's Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS) module, and the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS). The program and the Hillsborough County School Board submitted an Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's BSU on January 15, 2019, meeting the annual requirement.

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

The program maintains a policy and procedures to address five-year background re-screenings. The review determined only one employee was applicable for a five-year rescreening since the recently completed annual compliance review which concluded on April 26, 2019. Review of the one applicable employee confirmed rescreening/resubmission was submitted to the Department's BSU/Clearinghouse at least ten business days prior to the five-year anniversary or retained prints expiration date. The five-year rescreening was completed prior to the employee's 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.

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

The program has a policy and procedures for abuse reporting and for providing an abuse-free environment. The policy reflects youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline. Fourteen employee records were evaluated of which, all staff records contained a signed Department Code of Conduct and Ethics acknowledgement. New employee training upon hiring is delivered with the electronic Departmental on-boarding program and training system. A facility tour was conducted and postings of the Florida Abuse Hotline and Central Communications Center (CCC) telephone numbers were observed to be posted throughout the facility. The program's policy clearly outlines reporting procedures for all staff in the event of a youth reporting abuse. A resident handbook includes the youth's rights and the program's grievance process. The Florida Abuse Hotline and CCC telephone numbers are provided to each youth upon admission. The program completed a yearly Trauma Informed and Caring Environment (TRACE) self-assessment on May 18, 2019 which includes surveys geared to gauge the progress in implementing a trauma-responsive approach and caring environment for youth and staff.

Documentation within the last six months was reviewed for allegations of abuse to the Florida Abuse Hotline or CCC in which one report alleging abuse were found. The one applicable allegation documentation confirmed a report was made by staff to the CCC within two hours of staff being made aware of the incident. Management took immediate action to gather the facts concerning the allegation and determined during the investigation the allegation was unsubstantiated. An internal investigation report of the incident was evaluated and reflected management immediately placed the staff on administrative leave pending the outcome of the investigation. Seven interviewed staff and an interview with the executive director (ED), confirmed the program's abuse reporting practice. Seven interviewed youth reported feeling safe in the program and indicated all staff are fair and consistent in their treatment of the youth.

Each youth reported never being denied access to contact the Florida Abuse Hotline and confirmed staff would ensure them the opportunity to call if needed.

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

The program maintains a policy and procedures which address management's response to allegations. A review of internal incidents and reports made to the Department's Central Communications Center (CCC) found the program had one incident concerning allegations against staff for incidents of physical, psychological, and/or emotional abuse since the last annual compliance review. Documentation confirmed a call was made by staff the CCC within two hours of staff being made aware of the incident. Reviewed documentation for the incident reflected management immediately initiated an internal investigation and placed the employee on unpaid administrative leave until findings of the case were determined. The incident required law enforcement intervention and Department of Children and Families (DCF) protective investigator to evaluate the allegation. During an interview with the executive director (ED), it was reported staff are trained on incident reporting as part of their pre-service training. An interview with the ED indicated there was one staff disciplinary action due to allegations of abuse towards a youth in the program since the last annual compliance review.

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

The program maintains a policy and procedures to address reporting incidents occurring at the program to the Department's Central Communications Center (CCC). The program had ten incidents reported to the CCC during the last six months, of which five were reviewed. The reviewed documentation validated each incident was reported to the CCC within the mandatory two-hour time frame and in accordance with CCC reporting procedures. In all cases, CCC reports required an accompanying logbook entry and all five were properly documented. A comparison of reportable incidents during the last review period revealed there was not an increase of the reportable incidents since the previous annual review period. A review of the program's internal incident reports and grievances did not reveal there were any incidents which should have been reported to the CCC and were not. The program's executive director stated all youth are explained their rights and how to report abuse during their orientation.

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 regulating the employment of Protective Action Response (PAR) tactics on-site. The program's PAR plan was submitted to the Department's Office of Staff Development and Training on January 6, 2019 and approved by the regional director on January 14, 2019. The program had three PAR reports since the last annual compliance review; therefore, the minimum sampling of five PAR reports could not be met. All three reports reflected a review by a PAR-certified instructor, reports were processed within the seventy-two hour required time frame by all required parties, and a post-PAR interview was conducted within thirty-minutes of each incident. A review of the PAR incident reports and comments by the executive director (ED) or designee within seventy-two hours of the incident, was found in each PAR report. Each report was examined by a supervisor and a PAR instructor to determine if use of force was consistent with the policy in each PAR report. None of the three PAR instances required a medical PAR report as no youth or staff injuries were incurred due to the incident. None of the three PAR incidents involved the employment of mechanical restraints. Additionally, a monthly summary of all PAR incidents within the last six months, was submitted to the Department within two weeks of the end of each month as required. The program's PAR rate decreased since the last annual compliance review. The program's PAR rate during the annual compliance review period was 0.34, which is below the statewide Residential PAR rate of 2.41. An interview with the ED indicated PAR incidents are documented in the facility logbook, discussed with management team during the daily meetings, and a PAR report is completed for each PAR incident which is maintained in a binder organized by month.

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

The program has policy and procedures addressing pre-service training. The program utilizes a pre-service training plan curriculum for all new staff which was submitted in writing, to the Department's Office of Staff Development and Training on February 7, 2019. The fourteen-day pre-service training is facilitated to new employees by utilizing a combination of instructor-led, web-based courses, and on the job training. Seven staff training records were reviewed for pre-service training. All seven records reflected staff completed the certification process within 180 days of hire and completed all required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. A review of all seven staff training records revealed documentation to confirm each staff exceeded the required 120 hours of pre-service training. All seven training records reflected the full fourteen days completion of pre-service training documented within the Department's Learning Management System (SkillPro) as well as job specific on the job training completion, which met the contractual requirements for training.

1.08 In-Service Training	Satisfactory Compliance

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

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

The program maintains a policy and procedures which governs annual in-service training requirements. The program has an in-service annual training plan which was submitted in writing, to the Department's Office of Staff Development and Training on February 7, 2019. In-service training begins the calendar year after a staff person completes their pre-service training and requires staff to complete a minimum of twenty-four hours of in-service training for each calendar year following. Training subject matter includes first aid, cardiopulmonary resuscitation (CPR), automatic external defibrillation (AED), professionalism and ethics, Prison Rape Elimination Act (PREA), updated training in Protective Action Response (PAR), dealing with the program's population (sex offenders), and suicide prevention training. All seven staff received more than the required twenty-four hours of in-service training as required by the program's policy. Three of the seven reviewed staff were supervisory staff. All three supervisors received eight hours or more of supervisory training on the topics of management, leadership, personal accountability, employee relations, fiscal, and communication skills which was documented in the Department's Learning Management System (SkillPro). All instructors were validated to be qualified to facilitate training which is provided to staff. The program has two licensed nursing staff who both have a current certification in both CPR and AED techniques.

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 which regulates training and implementation requirements regarding the grievance process. The policy explains the grievance process to be threefold (informal, formal, and an appeal phase). The informal phase is accomplished through a "Request To Talk" form being placed in one of the grievance boxes located on the youth dorms. Program policy dictates grievance boxes must be checked each shift by supervisors. The informal phase encourages resolution at the lowest level possible by giving the youth the opportunity to speak to the staff or peer they are having a problem with. The decision and any action taken will be reviewed with the youth who filed the grievance. If the informal phase does not gain resolution, the youth may progress to the formal phase by filling out the formal grievance form and placing the form in the prospective grievance box located in the dormitory. Supervisors have four days from receiving the grievance to review, investigate, and respond to the youth. If a resolution is not achieved with the supervisor, the youth may pursue an appeal which will be filed with the facility grievance officer level. The decision and any action taken will be reviewed with the youth who filed the grievance. The third and final phase of the grievance lies with the program's assistant executive director or designee who must review grievance form responses within seventy-two hours of receiving the grievance. The decision and any action taken will be reviewed with the youth who filed the grievance. The program's grievance binder is

sorted by months of the year and each month has a dedicated grievance log along with the grievances filed for each month. There were two total grievances filed since the last annual compliance review which concluded on April 26, 2019; therefore, the minimum sample of five was unattainable. In both cases, grievances were resolved in the formal phase and processed in accordance with policy. Additionally, the youth signed an acknowledgement and checked the agreement box which indicated the youth did not want to pursue an appeal. Fourteen staff training records were reviewed and all training records reflected the documented grievance training provided to staff in the Department's Learning Management System (SkillPro). Both grievances were resolved during the formal phase and within seventy-two hours of the youth filing the grievance. Seven youth were interviewed and were able to explain the process for completing a grievance and the time frames in which the grievances are to be handled. Seven staff were interviewed and explained the process when youth request for a grievance, aid in completing the grievance form if needed, and the time frames in each phase. The executive director interview provided confirmation on the processing of grievances to include all three phases and the time frames associated with each phase.

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

The program facilitates Thinking for a Change (T4C), Impact of Crime (IOC), Young Men's Work, Pathways, Skillstreaming the Adolescent, and Life Skills Training (LST). The program utilizes thirteen employees to facilitate delinquency interventions in which all were properly trained by a certified facilitator to lead their assigned groups. A review of each facilitator's employee records confirmed all facilitators had the required experience working with adult and/or juvenile offenders prior to being trained to facilitate delinquency interventions. A review of the program's activity schedule and an observation of groups conducted at the time of the annual compliance review, confirmed the program is providing structured, planned programming, or activities at least sixty percent of the youth's waking hours. Group sessions are held daily and are one hour in duration. A review of the group sign-in sheets validated groups were delivered as prescribed. Seven youth case management records were reviewed and all contained an individualized youth performance plan which prescribed the youth participation in or completion of one or more of the delinquency interventions which address their top criminogenic needs. Youth are encouraged to demonstrate skills during treatment team meetings and through interactions with other youth and staff. An interview with the executive director confirmed youth are matched with clinicians based on the youth's individual needs identified in the pre-classification meeting during the youth's admission. The executive director interview also reflected the facility management team meets to discuss potential staff members who have the most suitable skillset and experiences to best facilitate groups. An interview was conducted with the clinical director which validated groups are assigned to youth based on individual needs and with only staff who have met all educational requirements to facilitate the interventions. Seven youth were interviewed and all youth reported they participate in a variety of groups which are geared to address their specific needs.

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

The program provides Life Skills Training (LST), Skillstreaming the Adolescent, Thinking for a Change (T4C), and Young Men's Work curriculum. The curriculum includes decision-making, problem-solving, critical thinking, interpersonal relationships and interactions, non-violent conflict resolution, and anger management training. Facilitator qualifications were verified and all staff received the proper training.

A review of the program's activity schedule confirmed groups are provided to the youth as scheduled. According to the program's schedule, groups are held Monday through Friday at 2:10 p.m. to 3:00 p.m. Weekend groups are held from 8:00 a.m. to 12:20 p.m. which includes four separate groups being held on both Saturday and Sunday. A review of seven youth case management records, seven youth clinical records, and group sign-in sheets for each curriculum confirmed all youth are currently participating in at least one of the above listed groups as articulated in the youth's performance plan.

An interview with the designated mental health clinician authority (DMHCA) indicated the program provides life skills training groups to the youth. These interventions are reflected in the youth's treatment plans and the groups address goals designed to target youth's life and social skill issues. Seven interviewed youth indicated they learn anger management, coping skills, staying drug free, think before acting, stress management, controlling and expressing sexual feelings, grooming behaviors, and can use the skills they learn in their daily interaction.

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

The program provides restorative justice activities through the Impact of Crime (IOC) curriculum to teach and reinforce the idea of restorative justice awareness to the youth in the program. The curriculums include victim impact, restorative justice, personal accountability, introduction to harm, consequences of making decisions, personal accountability, managing conflict, understanding the feelings of others, responding to anger, the road to reparation, and the impact of crime on victims, families, and the surrounding community. The reviewed documentation reflected IOC groups occur once a week for one hour in duration. Review of the daily schedule and group sign-in sheets indicated groups are held on-site as outlined. Reparation activities take place in the community and include activities such as Women Helping Others (a women's victim group), feeding local homeless, preparing community food baskets for Lighthouse Gospel Ministries, and grounds upkeep at a community playground coordinated with The River Church. The program also leverages guest speakers who offer a victim's or family of victims account of being impacted by crimes. Speakers share their personal story to help youth understand the residual effects of crime on others. Seven youth case management records were reviewed along with group sign-in sheets, in which all indicated services are being delivered as required. Interviews with the executive director (ED) and designated mental health clinician authority (DMHCA) confirmed the program utilizes a combination of restorative justice curriculum which is taught every Thursday from 11:30 a.m. to 12:30 p.m. combined with guest

speakers and community service to reach the youth. All seven interviewed youth reported they participated in IOC group and were able to explain what they do in groups.

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

The program is utilizing the Young Men's Work facilitator guide to deliver gender-specific programming. Young Men's Work is facilitated by the program's recreational therapist who is trained on facilitating the group which are held each Saturday from 6:00 p.m. to 7:00 p.m. The curriculum targets young men ages fourteen to nineteen and includes twenty-six sessions which focus on breaking the cycle of violence from generation to generation. The program also utilizes nursing staff to provide the youth with gender-specific health education by educating the youth on testicular cancer and teaching prevention tools such as self-screening. A review of group sign-in sheets confirmed each group was conducted with less than ten youth and was facilitated by a properly trained instructor. A review of seven youth case management records revealed the youth are currently participating in the Young Men's Work group. An interview with the executive director confirmed youth receive targeted gender-specific programming called Young Men's Work which is facilitated by the recreational therapist on a weekly basis. An interview with the designated mental health clinician authority (DMHCA) confirmed the DMHCA is personally responsible of overseeing the delivery of gender-specific programming to the youth as required in the service delivery guidelines.

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 maintains a policy and procedures regarding security, medical, and mental health alerts to ensure all staff are made aware when medical or mental health issues exist which may affect the security and safety of the youth in the program. The program's policy regarding alerts detail the alert system, how and when management reviews the alerts, who is responsible for updating the Department's Juvenile Justice Information System (JJIS), and how staff are informed of youth alert updates. The program utilizes the JJIS daily youth detail report to capture all open alerts and alert updates on youth in the production of their internal medical alert log, chronic conditions listing, and their master alert board located in the program administration conference room. The internal alert board contains a photograph of each youth, their Department identification number, age, therapist, case manager (CM), and colored blocks under the information designating each youth's specific alerts. Reviewed documentation indicated the program's internal alert information is actively reviewed daily, during shift briefings, and by the

program's supervisory staff. Seven youth records were reviewed for case management, medical, and mental health and substance abuse alerts, and all applicable alerts were accurately entered in JJIS. Discontinued or downgraded internal and JJIS alerts must be approved by medical staff, the program's assistant executive director, the clinical director, and/or a licensed mental health staff. Seven staff were interviewed and all seven reported they are informed of youth alerts during shift meetings and confirmed staff can review the program's alert board for youth alerts in the conference room.

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

The program has a policy and procedures in place which regulate the development, classification marking, and storage of youth records. The program maintains individual healthcare, mental health and substance abuse, and case management records for each youth. Seven youth's case management, healthcare, and mental health and substance abuse records were reviewed and each record contained all the required documents and were marked "confidential". The case management records contained all required documentation on the spine and front of the binder including each youth's name, Department Identification Number (DJJID), date of birth, county of residence, date of admission, and committing offense. The documents were organized into the required sections. All twenty-seven records (case management records, mental health and substance abuse records, and healthcare records for each youth) were secured inside a file cabinet in a locked room, when not in use. The program's file cabinets were marked "confidential".

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

The program promotes the gathering of constructive input from youth by using multiple feedback platforms. The program utilizes grievance forms, "Request To Talk" forms, weekly dormitory meetings, monthly town hall meetings, and the youth advisory board meetings to solicit input from the youth. The youth advisory board allows youth to provide feedback through monthly meetings as notes from each board meeting are collected and filed in the youth advisory binder. The youth advisory binder is broken up by months and contains board meeting minutes with agendas and sign-in logs. Each dormitory has an appointed mayor who holds weekly community meetings to discuss issues, concerns, and activities projected for each dormitory. The program also utilizes multiple youth surveys, and youth and parent entrance and exit surveys. Survey results are sent to the corporate office and formally reviewed and discussed during morning management meetings, monthly all staff meetings, and leadership meetings. Seven youth were interviewed and reported the process which youth can provide input through meetings. An interview with the executive director indicated the youth complete and sign the "Request To Talk" form as a first attempt to voice issues and concerns in the program and during the youth daily meeting. The youth advisory board has a formal process to promote constructive input by youth to the program.

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

The program has a nine-member community advisory board consisting of representatives of the law enforcement, community partners, the business community, the school district, volunteers, victim advocate, judiciary, faith community, and a parent/guardian of a former youth. The program emails invitations prior to the advisory board meeting to all representatives with one exception. The parent/guardian of a child previously involved in the juvenile justice system is telephoned and mailed an invitation prior to the advisory board meeting by the program's community liaison. A review of the community advisory board (CAB) supporting documents included agendas, minutes, coordination emails, and sign-in-sheets. The CAB binder contained documents which confirmed the hosting of quarterly advisory board meetings every ninety to a hundred-twenty days and proper representation from supporting agencies was present. The program director and community liaison actively solicits active involvement of interested community partners. An interview conducted with a current board member confirmed the board's frequent involvement in the program activities. An interview with the executive director (ED) revealed the program's community advisory board meetings are held quarterly and invitations are sent by email and a follow-up telephone call or reminder maybe conducted.

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

The program holds a multitude of meetings at various times and frequency which serve to assist in program planning and to ensure proper provisions for staffing. The meetings consist of morning management meetings, daily shift briefings, all staff monthly meetings, and on an as-needed basis supervisors are informally updated of any development changes. Additionally, to assist with employee morale; the program has an actual moral committee which identifies employee of the month, conducts fundraisers, staff appreciation events, and incentives for standout performers. The executive director (ED) explained how data is used for future program planning including the use of youth and parent/guardian entrance and exit surveys, youth and staff quarterly surveys, and employee satisfaction surveys. Results are discussed with staff and improvements are made with any deficiencies noted. Pertinent information such as published reports are discussed during monthly staff meetings and reflected on meeting minutes. Seven staff were interviewed and all indicated staff meetings are held daily to discuss an array of topics.

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

Staff are evaluated at ninety-days and then annually by their departmental head which includes staff comments, signatures and dates, as well as the supervisor's signatures, dates, and performance rating calculations. The performance evaluations were specific to the applicable staff's job description. All performance evaluations are confirmed by human resources (HR) and the executive director (ED). A review of fourteen staff records indicated the program maintains position descriptions for each position title which outlines the position expectations and essential functions, requirements of the position, knowledge, skills and abilities, physical requirements,

and work environment. The staff evaluations rate the staff's quality of work, modeling appropriate behavior, and each evaluation includes ratings on the staff's job-specific responsibilities. Seven staff were interviewed in which three staff reported they receive a formal evaluation yearly, two employees indicated they do not remember their last evaluation, and two newly hired employees stated they have not received an evaluation but expects to receive one very soon.

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

The program has policy and procedures which govern recreation and leisure activities. The program currently has one recreational therapist in accordance with the contract. The therapist is a bachelor's-level recreational specialist who holds a degree in sports and exercise science which meets the contract's requirements. The program maintains a monthly calendar of indoor and outdoor recreation activities planned for the youth, targeted to promote team building and leadership skills. Supervised and structured indoor and outdoor recreation activities available to youth includes basketball, flag football, table tennis, card tournaments, arts and crafts, cards, coordinated work-outs, and a plethora of board games. Inclement weather options are available on a daily calendar which includes options such as jumping jacks, squats, pushups, sit ups, cardio, and four-square competitions. Additionally, the therapist takes an active role in treatment team meetings where items such as body mass index (BMI), wellness plan goals, progression toward goals, and adjustment to plans are discussed. Seven interviewed youth indicated they are provided a variety of activities with varying degrees of mental and physical exertion throughout the day. The recreational therapist is responsible for planning, developing, and implementing daily recreation and leisure time activities designed to be physically challenging, educational, and constructive for the youth. The recreational therapist develops an individualized wellness plan to achieve each youth's desired goals while in the program. A review of the program's logbook reflected a minimum of an hour of recreation activity is provided daily for all youth. During an interview with the recreation therapist, it was indicated the recreation activities promote community wellness which allows youth to contribute to the group culture, promotes social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. Seven interviewed youth and seven interviewed staff indicated youth are provided with at least one hour of large muscle activity each day. Youth are provided an opportunity to provide input to program on recreation and leisure activities program along with other subject matter through the youth advisory board.

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 in place to address initial contact to the youth's parent/guardian as well as the committing court. The program's policy states within twenty-four hours of the youth's admission, case management staff contact the youth's parent/guardian by telephone to notify them of placement. Within forty-eight hours, case management staff provides written notification of the youth's placement to the parent/guardian. Within five working days, case management staff notifies the youth's committing court, assigned juvenile probation officer (JPO), and post-residential services case manager, as applicable. Seven youth case management records were reviewed and all records contained documentation on the Admission Chronological Record indicating the parent/guardian was contacted by telephone on the day of the youth's admission. All records indicated parent/guardians were mailed a parent admission letter on the day of admission, along with an approved telephone, correspondence, and visitation list, an invitation to attend and participate in the needs assessment meeting and treatment team meetings along with dates and times, a performance and transition plan goal proposal form, a map to and from the facility, program contacts, a letter requesting the youth's original birth certificate and social security card in order to obtain a state identification card, information on gang awareness regardless of whether or not the youth has any gang affiliation, Prison Rape Elimination Act (PREA) information, and a parent handbook. For youth were under the care of the Department of Children and Families (DCF), the DCF case manager was contacted on the day of admission by telephone and within forty-eight hours by mail with the required written admission documentation. All reviewed records contained a copy of the Judge Notification of Admission Letter sent to the committing court informing the court of the youth's placement which was mailed on the day of admission. All reviewed records contained a letter to the JPO informing the JPO of the youth's admission to the program which all were sent on the same day as the youth's placement. The JPO admission letter also contained an invitation inviting the JPO to participate in the needs assessment meeting as well as treatment team meetings. Dates and times of treatment team meetings for a period of six months were provided in the initial letter sent by the program.

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

The program has a policy and procedures in place to address youth orientation. Seven youth case management records were reviewed and all contained documentation indicating the youth participated in an orientation on the day of admission. The youth's assigned case manager completes the Orientation Checklist which addresses the program's rules, expectations and goals, and services applicable to the youth. This includes a review of the assignment to a treatment team, introduction to key staff, living unit, group leader, and primary counselor, review of the behavior management system and disciplinary actions, review of disaster preparedness procedures and emergency building evacuation procedures, tool identification/training,

student/student area search procedures, contraband policy and consequences for possession, daily facility schedule guidelines, dress code and hygiene expectations, resident rights, grievance and abuse reporting, access to emergency medical, dental, and menta health/substance abuse services including hours of sick call, civil rights, Prison Rape Elimination Act (PREA), performance planning and eligibility for release, visitation schedule, telephone and correspondence policies and procedures, release criteria and anticipated length of stay, review of personal property, criteria for off-campus activities, rules and regulations regarding youth conduct, and a review of the student handbook. Information contained on the orientation checklist is discussed with the youth by the case manager on the day of admission. Once all information is reviewed, completed forms are signed and dated by the both the youth and the case manager. All records contained a copy of the youth handbook including a signature page which was signed by the youth and case manager indicating the handbook was reviewed and a copy provided to the youth. All records included a personal property inventory and a list of contraband items. Upon review of all orientation documentation, all youth were required to complete and pass an orientation test. Completed tests were signed and dated by the youth and case manager and filed in the case management record. All youth admissions were documented in the facility logbook as well as on the chronological record maintained in the youth case management record. Seven youth were interviewed and stated their orientation started on the day of their admission to the program and included a review of program rules, schedules, and procedures. There were no admissions to the program during the annual compliance review period; therefore, an observation of the orientation process was not able to take place.

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 in place addressing how to obtain written consent of youth eighteen years or older prior to releasing or disclosing information related to the youth's physical or mental health screening, assessment, or treatment. Seven youth case management records were reviewed in order to determine if the program obtained written consent for providing youth information with the parent/guardian, Department of Children and Families (DCF), or other applicable agencies. One of the seven records reviewed were applicable as the remaining six youth were under the age of eighteen. The director of case management was able to provide the review team with seven additional examples in which all were found to be in compliance. All authorization to release information forms were found to be signed by the youth on their eighteenth birthday or upon admission to the program for those youth eighteen years of age at the time of placement. All authorization to release information forms listed the youth's name, date of birth, Department of Juvenile Justice identification number, date of arrival, the type of information which can be shared, and the name of the person who can receive the released information. All authorization to release information forms were signed and dated by the youth, a witness, and the executive director.

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

The program has a policy and procedures in place which address classification factors for newly admitted youth. On the day of admission, a classification meeting is conducted in order to assign the youth to a living unit, sleeping room, and youth group or staff advisor. During the classification meeting, a Youth Admission Classification form is completed which addresses the youth demographic information, physical characteristics, level of maturity, background information, medical needs, mental health/substance abuse needs, prior residential placements, current committing offense(s) and criminal background history, special needs, history of violence, gang affiliation, results of the Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and identified or suspected risk factors. Seven youth case management records were reviewed. Each record contained a classification form completed on the day of the youth's admission to the program which addressed assignment to a living area, sleeping room, and youth group or staff advisor. Although hard copies of the VSAB were completed and reviewed for all youth during the admission classification meeting, none of the seven case management records indicated these forms being entered into the Juvenile Justice Information System (JJIS) prior to the youth's room placement. During an internal audit, the program identified this deficiency and on November 21, 2019, the regional clinical director conducted a retraining with the director of case management and clinical director. VSAB screenings were then entered into JJIS on December 06, 2019. Participants in the classification meeting included the youth, case manager, therapist, medical, transition services manager, living unit representative, clinical director, community case manager, and executive director. The youth's parent/guardian were also contacted to participate in the meeting either in person or by telephone. Alerts when identified, were entered into the JJIS as well as the program's internal alert board, located in the administration conference room. An interview with the executive director confirmed factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are all considered when classifying a youth and assigning them to a dormitory and sleeping room. The program has a system in place for reassessing youth prior to considering an increase in privileges or freedom of movement, participation in work projects or other activities involving tools or instruments may be used as potential weapons or means of escape, or participation in off-campus activities. Reassessments are completed monthly during the youth's formal treatment team meeting. Forms are filed in a separate risk assessment log and includes assessment for participation in off-campus activities and to determine an increase in privileges or eligibility to participate in work projects or other activities involving tools. None of the youth in the sample size were eligible to participate in off-campus activities at this time; however, examples of other youth having these assessments completed were filed in the risk assessment log with all required signatures such as the case management, clinical director and/or mental health therapist, medical, and administration. All youth in the sample size had a monthly risk assessment which addressed areas to include but not be limited to, escape, completion of performance plan goals, and history of aggression.

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 in place which outlines notification of law enforcement regarding youth entering the program with suspected gang affiliation, or documented gang membership as well as for youth who are observed engaging in gang activities during their commitment to the program. Seven youth case management records were reviewed; however, none of the youth in the sample size were applicable for gang affiliation or membership. The program was able to provide two additional youth records for review of gang identification and notification. There were no other examples to review since the last annual compliance review. In both youth's case management records, there was documentation indicating notification to local law enforcement as well as notification of law enforcement in the youth's home county. Each record also indicated documentation of the youth's gang status being shared with on-site education staff and the youth's juvenile probation officer (JPO). The program maintains a gang tracker in which the following information is captured such as the name of youth, Department of Juvenile Justice identification number, dormitory number, room number, name of gang, Juvenile Justice Information System alert status, and notification status for law enforcement, education, and JPO. On a monthly basis, the director of case management mails a letter to the gang enforcement department at the Hillsborough County Sheriff's Office and shares any new gang information and/or gang-related activity with the agency.

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 in place which addresses the implement of gang prevention and intervention services. During the admission process, youth are screened for gang involvement on the Youth Admission Classification form as well as on a separate Security Threat Group Questionnaire. Youth identified as having gang involvement have an alert entered into the Juvenile Justice Information System (JJIS) as well as the program's internal alert board and are required to participate in gang prevention and intervention activities. The program uses the ARISE curriculum: Gangs: 50+ Stores of Fractured Lives as their main gang curriculum. The program also uses Impact of Crime (IOC) curricula as a gang prevention and intervention group. Seven youth case management records were reviewed; however, none of the youth in the sample size had gang involvement. The program was able to provide examples of two additional youth with gang involvement. One youth was admitted to the program as a documented gang associate, while the other youth was identified as having suspected gang affiliation during their commitment. Both youth were listed on the program's internal gang tracker. In addition, both of the youth had a gang packet filed in the gang log consisting of an admission card, fact sheet showing the youth's gang alert, copy of the gang alert entered into JJIS, Security Threat Group Questionnaire, gang criteria form, letters notifying required parties of the youth's gang affiliation or suspected affiliation, initial performance plan with the youth's gang intervention listed, and copies of completed gang assignments from the ARISE workbook. There was also documentation indicating the youth participating in a gang and violence prevention discussion with two law enforcement officers from the Tampa Police Department.

Gang information is also reviewed by program administration during monthly general staff meetings.

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

The program has a policy and procedures in place to ensure a Residential Assessment for Youth (RAY) is completed within thirty days of the youth's admission to the program and RAY reassessments are completed within ninety days after completion of the initial RAY assessment. Seven youth case management records were reviewed and all records contained an initial RAY assessment completed within the required time frame. In addition, all RAY documentation was maintained in the Juvenile Justice Information System (JJIS) with a copy of the youth's RAY Overview Report filed in each specific case management record. All seven records were applicable for RAY reassessments. All records contained a RAY reassessment which was completed within the required time frames. The updated RAY Overview Report along with the RAY Comparative Risk and Protective Report were maintained in JJIS while copies were filed in the youth's case management record.

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

The program has a policy and procedures in place to ensure the Youth Needs Assessment Summary (YNAS) is conducted within thirty days of the youth's admission to the program. Seven youth case management records were reviewed and all records contained a YNAS which was completed within the required time frames. Prior to the youth's case manager completing the YNAS, a needs assessment meeting is conducted with the assigned treatment team to discuss the youth's needs and to prioritize goals. Parent/guardians and the juvenile probation officer are also encouraged to participate either in person or by telephone. Each youth case management record contained documentation demonstrating participation from all parties.

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 in place to ensure all members of the treatment team, youth, juvenile probation officer, and parent/guardians are involved in the development of the youth's performance plan within thirty days of admission to the program. A needs assessment meeting is facilitated by the youth's assigned case manager in which the treatment team comes together to discuss and prioritize the identified needs of the youth. Seven youth case management records were reviewed and all contained documentation of the individualized performance plan being developed within the required time frame and developed following the youth's initial needs assessment. The youth's intervention and treatment team was present during the development of the performance plan as indicated by documentation of the youth's needs assessment meeting and included participation from the treatment team leader (youth's case manager), youth, administrative representative, living unit representative, mental health treatment staff, educational staff, and the youth's Department of Children and Families (DCF) case manager, as applicable. In all seven case management records, the individualized performance plan was signed by the intervention and treatment team leader, program administration, mental health staff, direct care/living unit staff, education/vocation staff, the community case manager, and the youth. In each of the seven case management records, there was documentation sent to the youth's parent/guardian from the assigned case manager requesting they review, sign, and return the signature in the self-addressed stamped envelope provided by the program. One case management record contained an individualized performance plan signature sheet signed by the youth's parent/guardian. This sheet was attached to the original performance plan and filed in the youth's case management record. All performance plans contained individualized goals based on the prioritized needs of the youth. The top three criminogenic needs were met and documentation was provided if the needs were re-prioritized based upon identified needs of the youth. Delinquency interventions, court-ordered sanctions, transition activities, and wellness recreation needs were included in each performance plan. In addition, performance plans listed the responsibility of staff in completing the goal, responsibility of youth in completing the goal, start date, and projected completion/end date. Upon development of the performance plan and after signature by required parties, a transmittal letter and a copy of the plan is mailed to the committing court, juvenile probation officer, parent/guardian, and DCF counselor, as applicable. Seven youth were interviewed if they had a copy of their performance plan. All youth stated they received a copy. In addition, all seven youth stated they participated in the development of their performance plan and were familiar with their current performance plan 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 in place which addresses performance plan revisions. After creation of the individualized performance plan at thirty-day intervals, the assigned treatment team meets to formally review the youth's performance plan goals and determine whether or not revisions are necessary. In addition, every ninety days after completion of the initial Residential Assessment for Youth (RAY), case management staff complete a RAY reassessment and should the results warrant, will revise the youth's performance plan goals. Seven youth case management records were reviewed. Two records contained documentation revealing the youth's performance plan was revised based upon RAY reassessment results. A copy of the RAY reassessment was attached to the Formal Treatment Team Progress Review form along with documentation of the proposed revision. Six records contained documentation indicating the youth's performance plan was updated in order to facilitate transition activities during the last sixty days of the youth's commitment. Performance plan revisions were reflected in the updated performance plans.

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 in place to ensure performance summaries and transmittals are completed within the required time frames. At each ninety-day interval beginning ninety days from the signing of the youth's performance plan, the intervention and treatment team meets to create a performance summary. In addition prior to the youth's release, discharge, or transfer from the program; the intervention and treatment team will meet to create the performance summary. Seven youth case management records were reviewed for the completion of performance summaries. All seven youth records contained documentation a performance summary was completed prior to the youth's release from the program. All performance summaries included the youth's status on each performance plan goal, the youth's overall treatment progress, academic status to include credits earned, performance, and behavior in school, youth's behavior, level of motivation/readiness to change, interaction with peers, interaction with staff, overall behavior adjustment to the program, and significant positive and negative events. Four youth had a release summary completed, all four contained a justification for release. Upon the youth's assigned case manager completing the performance summary, the document was signed and dated by the treatment team leader, staff member preparing the performance summary, executive director or designee, and the youth. There was documentation in all applicable records indicating the youth could read and add comments to each performance summary prior to signing them. Seven youth were interviewed and all youth indicated they received a copy of their performance summaries. Notes entered into the chronological records documented case management staff provided youth with a copy of their

performance summary. All case management records contained the original performance summary. Within ten working days, a copy of the original performance summary along with a transmittal letter was sent to the committing court, juvenile probation officer, parent/guardian, and Department of Children and Families counselor, as applicable. Supporting documentation was maintained in the youth's case management record. Three closed records were reviewed for discharge and release summaries. All three records contained the original release summary which included the justification for the youth's release from the program. All records contained a pre-release notification (PRN) completed at least ninety days prior to the youth's release. All summaries and PRNs were signed by the appropriate parties and maintained in the youth's closed case management record. All three records contained notification to the parent/guardian confirming the youth's release date once the program received the approved PRN from the committing court. All three closed records contained a completed exit Residential Assessment for Youth.

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 in place to ensure parent/guardians are involved in the case management process. At admission to the program, the assigned case manager contacts the youth's parent/guardian and informs them of the youth's safe arrival to the program. An admission packet is then mailed by the program to the parent/guardian which includes a parent handbook as well as a Performance Goal Proposal form where parent/guardians can provide input into the youth's individualized performance plan (IPP). Additional information, such as dates and times of needs assessment meeting and treatment team meetings, is also supplied. Upon creation of the IPP, parent/guardians are encouraged to participate in monthly formal treatment team progress review meetings, either in person or by telephone. Every ninety days after signing of the IPP, the youth's assigned case manager completes a performance summary and provides a copy to the parent/guardian. On a quarterly basis, the program facilitates a family day in which parent/guardians have an opportunity to interact with their child as well as program staff and be involved in the residential community. Parent/guardians are also encouraged to participate in transition and exit meetings to assist in the youth's successful release from the program. Weekly visitation is also available to family members who are listed on the youth's approved visitation list. Case management staff document parent/guardian contact (telephone calls, emails, or visitation) on the youth's chronological record which is maintained in the case management record. An interview with the executive director confirmed the activities listed above were taking place at the program to encourage and enhance parental involvement in the case management process. During the annual compliance review, the review team was able to observe three formal treatment team meetings, a Community Re-Entry Team meeting, and needs assessment meeting. In each of the meetings, the youth's parent/guardian was contacted by telephone and was able to participate and provide feedback. Seven youth case management records were reviewed and there was documentation in each record indicating the youth's parent/guardian or Department of Children and Families (DCF) case manager were involved in the assessment process, development of the youth's performance plan, progress reviews, and treatment team meetings. All records contained documentation the parent/guardian or DCF case workers were invited to and participated in treatment team meetings, visitation, and family days. Seven youth were interviewed and all youth confirmed their parents/guardians are involved in their case

management process as well as family therapy sessions with the youth's assigned mental health therapist.

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 in place to ensure representatives from the program's administration and residential living unit, education, and others responsible for overseeing the provision of intervention and treatment services are included in the treatment team meetings. Upon admission to the program, each youth is assigned to an intervention and treatment team. The youth's case manager completes a treatment team designation form listing the names and titles of the staff members comprising the youth's treatment team. Also, as part of the admission process, the youth's assigned case manager provides parent/guardians and the juvenile probation officer (JPO) with the dates and times of treatment team meetings for a period of six months to encourage their participation. The program also completes a daily schedule of meetings which is displayed outside of the conference room listing the date and time of each meeting. During the week of the annual compliance review, the review team was able to observe three formal treatment team meetings. The treatment team leader (the youth's assigned case manager), youth, living unit representative, therapist, administrative representative, parent/guardian, JPO, transition services manager, community case manager, and recreational therapist were present during the meetings. Education staff provided input which was reviewed and discussed during the meeting by the treatment team. The JPO was able to attend and participate in person while parent/guardians were able to participate by telephone. A review of seven youth case management records revealed each youth was assigned to a treatment team upon their arrival and each youth's treatment team consisted of the individuals required by the program's policy and Florida Administrative Code 63E-7.010. There was also documentation in each youth's record all required individuals were invited to attend each youth's formal treatment team meetings.

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 in place to ensure the incorporation of other plans into each youth's performance plan. Seven youth case management records were reviewed. In all instances, the performance plan of each youth included a goal which addressed the youth's compliance with their academic plan, mental health treatment plan, and wellness/recreation plan. Two youth were under the supervision or were involved with the Department of Children and Families (DCF). In both instances, the youth's DCF case plan was referenced by case management staff creating the performance plan. Documentation filed in each youth's case management record indicated ongoing contact between the program and the DCF case manager. The program advised the review team they did not have any youth served by the Agency for Persons with Disabilities.

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

The program has a policy and procedures in place to ensure each youth and their intervention and treatment team meet on a bi-weekly basis (formally and informally) to review the youth's performance to include Residential Assessment for Youth (RAY) reassessment results, progress on individualized performance plan (IPP) goals, positive and negative behavior including behavior resulting in physical interventions, and treatment plan progress. Seven youth case management records were reviewed. Each record contained evidence of the youth's parent/guardian, juvenile probation officer (JPO), and other pertinent parties (case manager, transition services manager, recreation therapist, health services, education, administration, mental health therapist, living unit representative, and community case manager) actively participated in these formal treatment team progress review meetings. Formal reviews were conducted at least every thirty days and were appropriately documented in the youth's case management record. Each formal review included the information listed above as well as the youth's name, date of review, comments from treatment team members or others, and a brief synopsis of the youth's progress in the program. Each formal treatment team progress review contained a youth progress report section where the youth was afforded to make a statement and demonstrate skills they acquired in the program. In each of the seven case management records reviewed, there was documentation of bi-weekly informal treatment team progress reviews which included the same information as the formal treatment team meeting; however, the meeting was held with only the youth and their assigned case manager. During the annual compliance review, the review team was able to observe three formal treatment team meetings. In each meeting, the required treatment team members were present and actively participated in the meeting. For the three meetings observed, the youth's JPO attend in person while parent/guardians attended by telephone. Education, although not present at the meeting, did provide written input which was reviewed with the group by the treatment team leader. During each formal meeting, information of the youth's progress on each IPP goal, positive and negative behaviors, and treatment progress were reviewed. None of the youth were involved in any behaviors requiring staff to use physical intervention. All youth were provided with the opportunity to speak and demonstrate skills learned in the program. Seven youth were interviewed if staff members review their performance to include progress on performance plan goals, positive and negative behavior, and treatment progress. All interviewed youth confirmed this information is reviewed with them during treatment team meetings. In addition, all youth stated they are given an opportunity during treatment team meetings to demonstrate skills they have learned in the program.

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

The program has a policy and procedures in place which addresses the development and implementation of a vocational competency development program. The program, through the support and participation of the School Board of Hillsborough County, provides a Type 2 Vocational Programming. This type of programming instructs personal accountability skills and behaviors which will lead up to appropriate work habits for both employment and living. The

content of this program includes teaching effective communication skills, useful interpersonal skills, and valuable decision-making skills. These skills are both age and intellect appropriate. The career education component allows students to investigate possible career choices which would be aligned to the individual's skill set and intellect ability. Course work includes but is not limited to completing job applications, creating résumés, and participating in mock interviews. Three closed youth records were reviewed. All records have evidence of a completed sample employment application and résumé, and documentation of an appointment with the Career Source Center. The program offers career educational services such as Safe Staff, Serve Safe - Professional Manager, and Ready to Work certification opportunities for the youth. An interview was conducted with the lead teacher and the above information was confirmed in the responses.

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

The program has a policy and procedures in place which details how the facility integrates educational instruction (career and technical education, as well as academic instruction) into their daily schedule in such a way as to ensure the integrity of the required instructional time. The program provides an education component completely under the supervision and direction of the Hillsborough County School Board on a year-round basis. By statute, the students are required to receive a minimum of twenty-five hours of instruction weekly. In accordance to this, the program offers 300 minutes of academic instruction daily. The academic courses provided to the youth follow regular high school course curriculum allowing for course credit to be earned towards a regular high school diploma. A review of the master control logbooks, the standing academic calendar and schedule, an in-person interview with the program's lead educator, and surveillance videos all confirmed the classes were held on a daily schedule with very limited interruptions. Seven youth were interviewed on whether there were a lot of interruptions during educational instruction. All youth stated there were not many interruptions, with one youth stating "things are on time."

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

The program has a policy and procedures in place stating upon admission, staff and youth develop an education transition plan which includes provisions for continuation of education and/or employment. Three closed youth records were reviewed for education transition plan. Upon examination, it was evident each individual record contained a detailed education transition plan for the youth. Each education transition plan was created at the youth's admission to the program and was based upon the youth's specific goals following their release from the program. Each education transition plan identified key personnel related to the transition activities which included the youth, the youth's parent/guardian, the program's educational representative, post-release staff (including the youth's juvenile probation officer, if applicable), a certified school counselor from the school district of which the youth is returning to, and a registrar. The education transition plan also included an exit portfolio, which contained industry certifications, a schedule of post-release appointments with identified parties such as Career Source, and other parties which are directly related to the youth's transitional plan goals.

Included in the portfolios were all necessary documents needed to gain employment, a detailed educational/social review which identified post-release goals, and providers in the community to address such needs if applicable.

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

The program has a policy and procedures in place addressing the program's transitional planning process to include participation of the program and the youth in the Community Re-Entry Team (CRT) meeting. A review of three closed youth case management records found documentation of the treatment team planning for the youth's successful transition to the community upon release from the program. Each record also contained evidence of a transition conference summary being completed at least sixty days prior to the youth's targeted release date. Documentation confirmed each transition plan was developed by the youth, treatment team leader, executive director or designee, parent/guardian, and other pertinent treatment team members to include the mental health therapist, medical staff, education, transition services manager, living unit representative, director of case management, and juvenile probation officer (JPO). During the transition conference, the treatment team members reviewed transition activities listed on the youth's individualized performance plan, identified additional transition activities, identified target completion dates, and person responsible for completion. Each of the three closed records indicated evidence of the plan being sent with a request for return with signature to the parent/guardian and JPO. In two of the closed records, there was evidence of both the parent/guardian and JPO signing the transition conference signature page. In the third record, there was evidence of the parent/guardian returning the signature page, as requested. All three youth records contained evidence the youth and case manager participated in a CRT meeting held prior to the youth's release. Email invites were present in each closed record with documentation of the CRT meeting recorded on the transition chronological record along with the date and the initials of the staff member making the entry.

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

The program has a policy and procedures in place addressing the program's exit process to include assembling an exit portfolio for each youth to assist the youth once released back into their home community. A review of three closed youth case management records found all

records contained an exit portfolio. Each exit portfolio was discussed and initiated for the youth at the transition conference and verified during the exit conference. Each exit portfolio included the youth's State of Florida identification card, social security card, birth certificate, transition plan, and a calendar containing the dates and times of follow-up appointments for the youth to attend in their home community which was documented on the "A Plan for Success" form. Four youth were required to complete community service hours which were documented on the Community Service House Tracking Log, notarized, and included as part of the exit portfolio. The portfolio also included completed sample employment applications, résumé, vocational certificates such as SafeServe and SafeStaff, educational records, and school transcripts. Upon release from the program, the completed exit portfolio was provided to the youth and documented on the Acceptance of Custody form which is signed and dated by the parent/guardian, executive director, and case manager. In addition, program staff forwarded the exit portfolio information to the juvenile probation officer and documented on the Closed Youth Case Record Cover Sheet, which is signed by the person completing the checklist as well as the clinical director and/or director of case management. The United States Postal Services signature confirmation tracking label was affixed to the checklist.

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

The program has a policy and procedures in place which addresses participation of the youth and treatment team in the exit conference. Three closed youth case management records were reviewed for the completion of an exit conference. All three records contained documentation an exit conference being conducted after the juvenile probation officer (JPO) was notified of each youth's release. All records reflected the exit conference was conducted at least fourteen days prior to the youth's release in which the status of goals developed at the transition conference were reviewed and release plans were finalized. A summary of the conference was found in all three records and included the date, signatures, names of participants by phone, and a summary of pending transition goals. The following participated in the exit conferences for each youth the treatment team leader, parent/guardian, education representative, case manager, mental health therapist, transition services manager, living unit representative, executive director, and youth. In all three records reviewed, the youth's parent/guardian participated by telephone while the assigned JPO participated by telephone in two of the three meetings. Exit conferences were held separately from the transition meeting and Community Re-Entry Team meetings. A review of the Department's Juvenile Justice Information System confirmed each youth's date of admission and date of release correlated with the case management records.

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 single licensed mental health clinician (LMHC) serving as the designated mental health clinician authority (DMHCA) in the position of the clinical director. The mental health team consists of the clinical director, assistant clinical director, and seven licensed clinicians. Exhibit 11 of the contract requires all clinicians to be licensed therapists as set forth in Rule 63N-1.0081. The DMHCA serves as a member of the management team. Reviewed documentation confirmed the clinical director is on-site full time five days a week. The facility operating procedures includes the clinical director serves as the designated mental health clinician authority (DMHCA) full-time and available twenty-four hours a day, seven days a week. The program is staffed with an assistant clinical director who is a full-time licensed clinician serving as back-up to the clinical director.

Interviews with the clinical director indicated the clinical director is a full-time staff on-site five days a week, weekends and additional hours as needed, and on call twenty-four hours a day, seven days a week. The DMHCA responsibilities are coordinating and implementing all clinical service delivery including intake assessments, comprehensive mental health/substance abuse evaluations, treatment planning, transition and discharge planning, as well as group, individual and family counseling services. Insures suicide prevention and crisis intervention services are conducted in accordance with best practice and Department standards. Oversees all clinical, delinquency intervention, restorative justice, and gender specific treatment groups are implemented and conducted within the required service delivery guidelines. Reviews all clinical documentation to insure quality and is completed in a timely fashion. The clinical director described the level of communication between herself, the clinical staff, and case management staff to include daily morning phase meetings, as well as monthly clinical department meetings. Communication with the clinical staff occurs as needed as well by telephone, email, and in person throughout the day. The DMHCA also maintains an open-door policy in which the clinical staff can seek out assistance, as needed.

An interview with the DMHCA indicated direct clinical services provides clinical leadership to all clinical and case management staff by way of supervision and clinical consult. The DMHCA is specially trained to conduct Pathways and Thinking for a Change groups and maintains juvenile sex offender therapy certification which was confirmed by the Office of Health Services (OHS). The DMHCA will also assist with group coverage when needed. Regarding direct mental health and substance abuse services, neither the DMHCA nor the assistant clinical director carry a youth case load. However, through the course of a year, the DMHCA provides the required direct care mental health and substance abuse services while filling in for scheduled and unscheduled clinical staff absences.

The position description for the clinical director includes the staff filling the position is the licensed staff person with training specifically in mental health services coordination. This person is responsible to ensure coordination and implementation of treatment plans and service delivery for youth requiring mental health substance abuse or other specialized services. This person is also responsible for the delivery of direct clinical services for clients, providing clinical supervision tor treatment staff, educational staff and clinical consultation to the company. The position is a full-time status with additional evening and weekend hours as needed.

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 policy and procedures addressing licensed clinical staff. Five staff hold clear and active credentials as licensed mental health clinicians (LMHC) and two staff hold clear and active credentials as licensed clinical social workers (LCSW) with the Department of Health, Bureau of Medical Quality Assurance. All seven of the clinician's license's expire March 31, 2021.

Each of the seven clinician's personnel records contained documentation of completion of the required training and bi-annual continuing education units (CEU's) for holding them as juvenile sex offender therapists. A review of training documentation revealed the certified training was hosted by the Healthcare Training Institute for Juvenile Sex Offenders which were confirmed by the Office of Health Services

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 policy and procedures addressing non-licensed clinicians. The contract requires the exclusive use of licensed clinicians, as a result, the program does not utilize any non-licensed clinicians.

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 policy and procedures addressing mental health and substance abuse admission screening. The facility utilizes a number of screening tools at admission to determine needs for further assessment. All youth are screened with the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2), Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR).

Since the specialized population is considered more at risk than the ordinary juvenile residential program, all youth receive the Assessment for Suicide Risk (ASR) regardless of the results of the MAYSI-2 screening. Procedures also includes review of the commitment packet information, reports, and records. A licensed clinician conducts an initial clinical interview with each youth documenting a review of all available records.

A review of seven youth records revealed each youth received screenings utilizing the required tools on the day of admission administered by the case manager. Each of the youth records contained an initial clinical review by a licensed clinician reviewing both the screening instruments and all available documentation. One youth screened for suicide risk was placed on constant supervision and referred for an ASR. All seven youth were referred for further assessment including a comprehensive psychosexual mental health and substance abuse assessment and a psychiatric evaluation.

The MAYSI-2 for one youth was marked as a referral for further assessment based on the MAYSI-2 screening; however, there were no hits signifying the youth was at risk.

An interview with the clinical director revealed upon admission, all youth are administered the MAYSI-2 as well as the VSAB. Additionally, information is gathered through an intake records review and completion of an ASR and an initial interview. All youth are also administered the Trauma Symptom Checklist assessment to help in gathering information for the purpose of a comprehensive mental health and substance abuse assessment. An admission classification meeting is conducted with all departments on the day of admission which includes the youth's legal parent/guardian, assists in identifying needs for referrals for comprehensive evaluations, mental health/substance abuse alert status updates, and the need for placement for precautionary observations when indicated. In addition, at any time following a youth's admission to the program, any member of the treatment team may initiate a mental health/substance referral through the Mental Health and Substance Abuse Referral Summary form to request a comprehensive mental health and substance abuse evaluation. The evaluation shall be completed within thirty days of receipt of the referral, which will then be forwarded to the primary therapist for completion.

An interview with administration revealed an admission classification meeting is conducted for all admitted youth on the day of admission as part of the admission intake process. Within the admission classification meeting, the findings of the MAYSI-2 screening, records review, VSAB., ASR, and the initial interview processes are reviewed. The classification team identifies needs for referrals for comprehensive evaluation, mental health/substance abuse alert status as well as the need for placement on precautionary observation when indicated. At any time following a youth's admission to the program when behavior warrants evaluation by a mental health professional, staff or treatment team may initiate a mental health substance abuse referral form requesting a comprehensive evaluation. The comprehensive evaluation shall be completed within thirty days of referral.

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 policy and procedures addressing mental health and substance abuse comprehensive evaluations. The procedures include each youth receives a new comprehensive psychosexual mental health and substance abuse evaluation within thirty days of admission.

A review of seven youth records revealed each youth received a new comprehensive psychosexual evaluation within thirty days of referral. Each of the evaluations contained all required elements including reason for evaluation, relevant background information, behavioral observation, mental status exam, procedures administered, discussion of findings, diagnostic impressions and recommendations. The substance abuse evaluations included patterns of alcohol and drug use, impact of alcohol and other drug use on major life areas, and risk factors for continued use. Each of the seven evaluations addressed the problems identified at the screening. Six of the seven evaluations included recommendations of the psychiatrist. One evaluation was completed two days after the psychiatric evaluation and the recommendations were not included in the evaluation.

Interviews with administrative staff revealed the comprehensive assessment is completed within thirty days of intake. If a youth presents with symptoms of emotional disturbance or mental illness which were not initially identified, a mental health referral is completed by either youth or attending staff to a mental health therapist to determine the need for additional mental health assessments or treatments.

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

The program has policy and procedures addressing mental health and substance abuse treatment. Procedures include group therapy is limited to ten youth and substance abuse treatment groups to fifteen youth. Each youth treatment plan indicated individual therapy was planned for once a week and family therapy were planned for once a month. Groups were planned seven days a week. All seven youth received psychiatric services during their stay including monthly medication monitoring, when applicable.

A review of seven youth records for mental health and substance abuse treatment revealed each record contained a properly executed Authority for Evaluation and Treatment (AET) form, a signed Youth Consent for Substance Abuse Treatment form, and a signed Youth Consent for Release of Substance Abuse Treatment Records form. Properly signed consents were completed for the youth eighteen years of age.

In addition, one youth record contained a court order providing consent for mental health and substance abuse evaluation and treatment including psychiatric medication.

Each record also contained counseling therapy progress notes on a form which included all required elements. Each record included a page indicating which therapist was personally assigned to the youth for treatment and treatment team events. All seven youth records documented receipt of treatment according to the treatment plan protocol consistently. Some family therapy did not occur monthly; however, there were chronological notes indicating attempts by the therapist to arrange the monthly therapy encounters. All seven youth received psychosocial skill training using the Skillstreaming curriculum addressing specific symptoms on the treatment plan.

The clinical director was interviewed regarding how the team ensures services are provided. The response included services are based upon the findings of the comprehensive mental health and substance abuse evaluation, an individualized treatment plan is developed which outlines the service provision for all identified treatment needs including group, individual, and family counseling services, as well as psychiatric and medication management interventions. If a youth has an identified substance abuse treatment need, services shall be specified on the treatment plan and services shall be provided as indicated. Treatment interventions and frequency are outlined on the treatment plan and are reviewed and updated if needed, on a monthly basis. The management team discusses services provided in monthly management meetings to ensure the provision of services and program fidelity. As a part of the quality improvement process, both regional leadership and the clinical director monitors youth files and completes monthly fidelity monitoring to ensure services are provided to youth in accordance with their individualized treatment needs.

Seven youth were interviewed regarding if they were participating in specialized groups. All seven youth indicated they receive specialized therapy. Youth listed the types of groups offered at the program as sex offender therapy, Thinking for a Change (T4C), trauma, substance abuse, dog therapy, Impact of Crime (IOC), financial group, aquaponics, Pathways, and Passports.

All treatment including individual, group, and family therapy was delivered by licensed therapists. A review of training records revealed each therapist was trained in delivery of the specific curriculum provided.

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

The program has policy and procedures addressing treatment and discharge planning. The process includes each youth receives an initial treatment plan upon admission and an individualized treatment plan within thirty days of admission. The discharge planning process begins at admission.

A review of seven youth mental health and substance abuse records revealed each youth received at admission an initial treatment plan documented on the required form which contained all required elements including signatures of the licensed mental health professional and all treatment team members who participated in the development of the plan. Five youth entered the program already taking prescribed psychotropic medication upon admission. Four of the initial treatment plans included the medication, recommendations for the youth to have an initial psychiatric evaluation, and frequency of medication monitoring. One of the initial plans included the medication and recommendations for the youth to have an initial psychiatric evaluation but did not include medication monitoring.

All seven youth records included an individualized treatment plan completed within thirty days of admission and following completion of the comprehensive psychosexual evaluation. Each of the

treatment plans included all required elements and were signed by the licensed mental health professional. In addition, the clinical director countersigned each plan along with all the treatment team members. Copies of the treatment plan was sent to the parent/guardian and juvenile probation officer if they were unable to participate in the treatment team. The individualized plans consistently included psychiatric services including the applicable medication and frequency of medication monitoring.

Each of the seven records documented treatment team was conducted in thirty-day intervals. Each of the seven records included a total of twenty-four treatment team reviews. Each review included all required elements. Progress notes documented youth received services as stipulated in the individualized treatment plan.

None of the seven youth records were applicable for discharge plans. Three closed records were reviewed for discharge planning. Each of the three records contained a mental health and substance abuse discharge plan with all required elements documented on the required form and completed prior to the exit staffing. The records documented the parent/guardian and juvenile probation officer (JPO) were notified in advance of the exit staffing. The exit staffing documented the discussion of the mental health and substance abuse discharge plan with all parties attending. When the parent/guardian and JPO were unable to participate, the plan was sent to them by mail/email. A copy of the mental health and substance abuse discharge plan was provided to each of the three youth and applicable parent/guardian at discharge.

The clinical director described the treatment planning process as treatment planning begins at intake. At admission, an initial treatment plan is developed using the youth’s history and results of assessments completed during intake. The mental health/substance abuse counselor incorporates information obtained from the various disciplines into the youth's comprehensive bio-psychosocial evaluation which is due twenty-one days from admission. From the comprehensive bio-psychosocial evaluation and within thirty days of admission, the mental health/substance abuse counselor with the assistance of and input from the youth and the family develops an individualized treatment plan with goals and objectives which specifically address youth's individualized treatment needs. The goals and objectives are derived from information about the youth's needs as identified on the comprehensive bio-psychosocial. The mental health/substance abuse counselor sends a copy of the treatment plan parent/guardian response form to the parent/guardian and JPO at admission. If the form is not returned, the therapist will review the form with the parent/guardian over the telephone to assist with the development of the treatment plan. Further, the youth will assist in identifying goals they would like to address while in the program. The mental health/substance abuse therapist also gathers input from the various departments such as education, medical, primary youth counselor, case management, and JPO to help identify youth's needs and goals while in the program. Treatment plans are reviewed on a monthly basis at the youth's formal treatment team meeting.

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 provides specialized sex offender treatment services. The program is staffed with seven full-time licensed mental health professionals each who has completed the training and continuing education units (CEUs) required of juvenile sex offender (JSO) therapists. The staff schedule includes therapists are on-site seven days a week. Staffing also includes a licensed

psychiatrist to provide psychiatric evaluation, medication management, and participation in treatment planning. Counselor caseloads are one counselor to ten youth.

Programming includes JSO treatment planning, JSO therapy, individual, group, and family therapy (including mental health and substance abuse counseling), crisis intervention, and therapeutic activities such as skill training and relapse prevention.

An interview with administration regarding specialized treatment revealed the program utilizes the Pathways curriculum for specialized treatment groups which focuses on sexual acting out. This curriculum is considered by the Department as a delinquency intervention practice with demonstrated effectiveness and focuses on strength-based methods to help clients develop healthy and productive lifestyles away from sexual acting out behaviors. Pathways also utilizes a restorative justice theme emphasizing concern for restitution, development of victim empathy, and personal responsibility. The treatment team focuses on understanding the offense cycle as well as understanding the antecedents of sexually acting out.

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

The program has policies and procedures addressing psychiatric services. The psychiatrist is a medical doctor who holds a clear and active license with the Department of Health, Bureau of Medical Quality Assurance which expires on January 31, 2021. The psychiatrist is certified in adult psychiatry by the American Board of Psychiatry and Neurology, Inc. (ABPN). The psychiatrist completed a fellowship in child and adolescent psychiatry following s residency. The psychiatrist is on-site weekly and provides psychiatric evaluations, medication monitoring, and consultations twenty-four hours a day, seven days a week.

An interview with the psychiatrist revealed the psychiatrist provides psychiatric evaluations, medication management, review side effect profile, maintains contact with parent/guardian regarding the medication management, meets with the treatment team weekly on a face-to-face basis, and meets with the program director weekly. There are no concerns with the health care at the program.

A review of seven youth records revealed each youth received a new psychiatric evaluation within at least fourteen days of admission. Five of the youth entered the program on medications and the psychiatrist continued the medication by telephone consult until an evaluation could be provided on-site. Each of the evaluations was completed on the Clinical Psychotropic Progress Note (CPPN) which included page 3. One of the youth not on medication upon admission was prescribed medication following the initial evaluation. The evaluation was documented on the CPPN which included all three pages. A seventh youth not on medication upon admission was not prescribed medication following their initial psychiatric evaluation. However, subsequently mental health staff referred the youth back to the psychiatrist who prescribed medication following an updated evaluation which included page proper medication authorization on 3 of the CPPN.

An interview with the clinical director revealed the clinical director facilitates a weekly psychiatric treatment team meeting with the psychiatrist and treatment team members to review youth

receiving psychiatric services. The psychiatrist is also available on call twenty-four hours a day, seven days a week when needed for consultation.

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

The program has a suicide prevention plan in place which received an annual review on July 19, 2019. The plan included procedures for identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process.

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

A review of seven youth mental health and substance records revealed each youth received an initial Assessment of Suicide Risk (ASR) at admission. One of the youth was maintained on constant supervision and the ASR recommended continuation on suicide precautions/constant supervision. The ASR was completed by a licensed mental health professional who notified and consulted with the program director within the require time frame. The consultation was documented on the ASR.

None of the remaining six youth were applicable for monitoring for suicide precautions. Two additional youth records were reviewed for suicide prevention services. One youth was placed on suicide precautions at admission and maintained on constant supervision following recommendations by the licensed mental health professional conducting the initial ASR. The same youth had a subsequent occasion with self-reported self-injurious thoughts and was placed on constant supervision, referred to mental health, and received an ASR. A third reviewed youth record was associated with a self-reported self-injurious thinking, who also was placed on constant supervision and received an ASR.

There were only three youth applicable for suicide risk findings during the mental health and substance abuse screening utilizing the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2). All three applicable youth screened for suicide risk at admissions were placed on constant supervision and received an Assessment of Suicide Risk (ASR) immediately following the screening. Two of the youth were stepped down to standard supervision. One youth was continued on suicide precautions based on recommendations documented on the ASR. Subsequent to admission, one of the three youth received a referral for suicide risk and was placed on constant supervision and referred to the licensed provider. Within twenty-four hours of the referral, the licensed provider performed an ASR and recommended the youth to

be stepped down to standard supervision. Notification to and consultation with program administration, parent/guardian, and juvenile probation officer was documented on the ASR within the required time frame in all four instances.
The clinical director indicated the program does not use secure observation. A review of seven youth records did not reveal any instances of the use of secure observation. A review of logbooks did not reveal any use of secure observation.

The clinical director described the measures taken for referral/assessment by a mental health professional for a youth who appears to be acutely suicidal. They include trainings are conducted to ensure staff members know how to properly intervene when a youth appears to be suicidal or in crisis. When a youth appears suicidal, the clinical director is immediately notified. If any mental health professionals are in the building, an ASR is completed. If the youth is at risk for suicide, the youth will be placed on precautionary observation with constant supervision, documented every thirty minutes, and conducted by direct care staff. The precautionary observation log is started and the restrictions checklist is completed and attached to the observation log for staff review and given to the staff member who will be observing the youth. The clinical director provides twenty-four hours a day, seven days a week coverage for telephonic consult on youth who appear acutely suicidal.

The clinical director described how staff are notified if a youth is at risk of suicide in the following manner. The precautionary observation log is begun and provided to the staff members who will be observing the youth. The alert system is started. The youth's status is also updated in the logbook with all pertinent information. Further, the youth’s designation is put on the alert board. The therapist notifies the youth's parent/guardian and the juvenile probation officer to inform them of the youth’s placement on suicide precautions. Direct care staff are also informed prior to their shift during the staff briefing.

Seven staff were interviewed regarding required actions if a youth expressed suicidal thoughts. All seven staff indicated they would notify the supervisor. Six indicated they would notify mental health, five indicated they would provide constant sight and sound supervision, and one staff indicated they would document the supervision and search the youth and room for sharp objects.

Seven staff were interviewed regarding the location of the suicide response kit including the “knife for life,” wire cutters, and needle-nose pliers. All seven indicated the kit was on the mod, five indicated there was one in master control, three indicated in medical, and one indicated there was one in the van.

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.	

Four youth mental health and substance records were applicable for suicide precautionary logs. All four youth were placed on constant supervision documented on suicide precaution observation logs for the duration of the suicide precaution. The appropriate level of supervision was maintained, observations documented in real time, and did not exceed thirty minutes. The logs documented any suspected warning signs; however, none of the youth exhibited any signs during the period of precautionary observation. Each of the suicide precautionary observation logs were signed by the shift supervisor and mental health professional staff. The logs consistently documented safe housing requirements.

Three youth were interviewed regarding their time placed on precautionary observation. All three youth indicated staff were with them at all times while being supervised on precautionary observation. All three youth indicated they were never left alone while on precautionary observation.

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 policy and procedures addressing suicide prevention training. A review of seven pre-service and seven in-service training records revealed each staff received the required six hours of suicide prevention training during the review period. A review of mock suicide drills revealed drills were conducted on each quarter including a cut-down exercise for all shifts. A review of sign-in sheets revealed more than fifty-percent of all staff participated in at least one mock suicide drill semi-annually involving a cut-down exercise. The program maintained sign-in sheets for staff to review at the monthly drill review for the mock suicide drills they missed. Each staff signed the drill review sheet. The review confirmed all staff with daily direct contact with youth participated in at least one mock drill which included CPR annually.

An interview with administration indicated the program provides training on mock drills for staff which includes emergency response to suicide attempts or self-inflicted injury. Three of the seven interviewed staff indicated they participated in a suicide drill in the past twelve months.

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

The program has a crisis intervention plan separate from the emergency mental health and substance abuse services plan in place which received an annual review on July 19, 2019. The plan included notification, an alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The plan included the use of the Department's Crisis Assessment form.

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

The program has policy and procedures addressing crisis intervention services. Procedures include staff should utilize the Department's Crisis Assessment form when engaged in a crisis intervention. None of the seven reviewed records included a crisis assessment. An interview with the designated mental health clinician authority indicated there were no instances at the program in which a crisis assessment was completed.

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

The program has an emergency mental health and substance abuse services plan separate from the crisis intervention plan in place which received an annual review on July 19, 2019. The plan included immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services including Baker Act and Marchman Act, documentation, training (including mock drills), and review.

The program has identified two crisis units in the area to provide emergency mental health and substance abuse services. One of the crisis units serves youth seventeen years of age and under. The other crisis unit serves youth eighteen years of age and older.

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

The program did not utilize a Baker Act or Marchman Act procedure during this review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

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

The program contracts with a medical doctor to serve as the designated health authority (DHA). The doctor's specialty is internal medicine with experience in adolescent health. The DHA's license is clear and active in the State of Florida and expires on January 31, 2021. The program does not use the services of a physician's assistant or an advanced practiced registered nurse (APRN) for medical services. It was verified through the weekly physician clinic list which serves as the sign-in documentation for the physician for the last six months, confirmed the DHA was on-site weekly, every Monday for two hours, with one exception. One week the doctor came in on a Sunday prior to their vacation. The program has an active contract with a second medical doctor, who holds an active and clear license in Florida until January 31, 2022. The second doctor's contract indicates their services are to be utilized as a back-up to the DHA. There were no instances since the last annual review in which back-up services were needed. An interview with the DHA validated the DHA or the back-up is on-site once a week to complete initial physical exams, sick calls, periodic evaluations/exams, and referrals to specialists as needed. The DHA also confirmed being available twenty-four hours a day, seven days a week for emergency care and consultation which is noted in the program's contract.

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.	

A review of facility operating policy and procedures (FOPs) validated the executive director (ED) and the designated health authority (DHA) reviewed and signed each FOP on August 1, 2019 and August 5, 2019, respectively. The FOPs outlines the program's provision of healthcare services. The DHA approved and signed the nursing protocols on April 29, 2019. The protocols are written and authorized by the DHA and are not delegated to any other person. The nursing staff reviewed, signed, and dated the FOPs, treatment protocols, and procedures on April 1, 2019 and updated their review on November 4, 2019. The DHA creates and approves all treatment protocols and standing orders. All psychiatric related services and psychiatric medication management is performed by the program's contracted psychiatrist. A review of all psychiatric FOPs validated they were reviewed by the psychiatrist on April 1, 2019 and on August 5, 2019. Newly hired medical staff are required to participate in on-the-job training and orientation with the use of a comprehensive training plan. Training for new nursing staff could not be verified during this annual review since the only nurse hired since the program's last annual compliance review worked only one day before resigning. The program hired a new nurse and is scheduled to start the week after the annual compliance review. In an interview, the DHA verified their involvement with policy and protocol development.

4.03 Authority for Evaluation and Treatment	Satisfactory Compliance
Each program shall ensure the completion of the Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in the custody of the Department.	

Seven youth medical records were reviewed for valid Authority for Evaluation and Treatment (AET) forms. One of the seven youth was eighteen years of age and not applicable; however, the youth record contained a release of information signed by the youth which indicated who could receive information related to their medical care. Two of the seven youth were in the care of the Department of Children and Families (DCF); however, one of the youth's parent/guardian still have parental rights. The remaining DCF youth had a court order consenting to routine medical and dental treatment. A review of the remaining three records validated each record contained a valid AET and all were copies, with the word "copy" stamped on each.

An interview with the director of nursing, indicated they reviews all projected intakes in the Department's Juvenile Justice Information System to validate the youth's AET. If a new AET is required before admission, the director of case management contacts the juvenile probation officer and/or commitment manager to obtain a valid AET. When a youth turns eighteen years of age, the program has the youth sign a release of information which is filed in the youth's medical record.

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

The program has a policy and procedures to address parental notification when there is a significant change in the youth's condition and obtain consent when new medications and treatments are provided to the youth. A review of seven youth records revealed two youth were over the age of eighteen and not applicable for parental consent/notification. All remaining five records contained the appropriate Department forms mailed to the parent/guardian regardless of verbal consent. Four of the five youth were placed on new medication post admission and in all four records progress notes included verbal consents or attempts to obtain consent by the parent/guardian prior to starting a new medication.

Two of the seven youth were involved with the Department of Children and Families (DCF); however, parental rights had been terminated in only one of the two records. A review of the first record, indicates the program followed DCF Rule 65C by completing DCF form 5339 and obtaining a court ordered consent prior to administering newly prescribed psychotropic medication. The second DCF youth's record documented all parental notification letters were being sent to the parent/guardian and the DCF worker as required.

Three of the seven youth records documented a need for invasive dental care. A review of one youth's record verified the parent/guardian provided verbal and written consent prior to the procedure. The second youth is in DCF custody and a request has been sent to the court for the youth to receive the proper treatment. The program has reached out multiple times to the DCF worker requesting the courts approval and have stated they are working on it; however, no court approval has been given. The third youth is under DCF supervision but their parental rights have not been terminated. Several telephone calls were documented in the progress notes indicating the program's nurses have requested the parent/guardian to return the signed consent form. The program indicates they will follow up with the appropriate juvenile probation

officers next week. Neither youth's record documented sick calls or episodic events pertaining to complaints of dental pain.

One youth required notifications for medication changes and changes to their chronic condition. Five youth required for over-the-counter medications (OTC) beyond those covered by the AET. In each record, verbal and written notifications were documented. Regardless of telephone notifications, written notifications were sent to the parent/guardians for every notification for each youth. Four of the seven youth were taken off-site for treatment and notifications were made to the parent/guardians by telephone and in writing. Four youth were prescribed new medication and in each record verbal attempts to contact the parent/guardian were documented in the progress notes. Each contact with parent/guardians to obtain verbal consent were witnessed by staff.

A review of seven youth medical records revealed five of the youth were admitted on a psychotropic medication. One youth was over eighteen years of age; however, only one of the youth was prescribed a new psychotropic medication post admission. This youth was in DCF custody and the medication was not initiated until a court order was received. The court order specifically approves the medication by name and the approved dosage range. The remaining six applicable youth records revealed the youth had no significant changes, additions, or discontinuations to their medication regimen. Although consent was not required, in all four applicable records written notification along with copy of page three of the Clinical Psychotropic Progress Note (CPPN) was mailed out to the parent/guardian. Each of the seven youth records contained a copy of their immunization obtained through the Florida Shots system. One of the seven youth records indicated a need for the Hepatitis A vaccine. A consent form was sent to the parent/guardian with a request to sign and the program is pending receipt of the signed form. An interview with the director of nursing confirmed the program's practice and indicates verbal consents are obtained as soon as possible after an order is written by a physician and written notification to parent/guardians are mailed out within twenty-four hours. If a youth has an illness or injury which requires emergency medical services, all attempts are made to verbally contact the parent/guardian prior to the youth leaving the program and a call is made upon the youth's return with results of the emergency visit. If a youth is exempt from immunizations, the program requires parent/guardians to provide the appropriate form from the Department of Health.

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

The program has a policy and procedures to ensure youth receive routine healthcare screenings upon admission and readmission. The procedures indicates all youth see the nurse immediately upon admission or readmission when the youth has been out of the physical custody of the program. Seven youth medical records were reviewed and each record contained a completed Facility Entry Physical Health Screening (FEPHS) form completed by a registered nurse (RN) on the day of admission. A review of the youth's Face Sheet in the Department's Juvenile Justice Information System revealed none of the youth experienced a change in physical custody. An interview with the director of nursing indicates if a RN is not on duty at the time a youth is admitted or readmitted, a non-licensed staff individual will complete the FEPHS and a licensed professional would review it within twenty-four hours. There were no FEPHS

forms completed by direct care staff nor did the program have any records to provide as an example of this practice.

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

The program has a policy and procedures in place regarding youth orientation to healthcare services. The program's procedures states all youth admitted shall be provided with an orientation to healthcare services within twenty-four hours of admission. The nursing staff are responsible for providing orientation to each youth in writing and during an individual session. A review of seven youth medical records validated each youth received an orientation to healthcare services at the program on the day of admission. The healthcare orientation form was signed by both the registered nurse (RN) and youth on the day of the youth's admission. All required healthcare topics were included on the orientation form. The review confirmed each youth's Health Education form was utilized to document the required topics during orientation. A review of the program's healthcare contacts validated their accuracy.

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

The program's policy and procedures indicates the designated health authority (DHA) is informed on the admission day of all youth regardless of any medical conditions and are to be seen the next time the DHA is on-site. A review of seven youth medical records validated all seven youth were admitted with a chronic or suspected chronic condition and the DHA was notified by telephone upon admission for each youth, with one exception. One youth's record documented notification to the psychiatrist but not the DHA. Each applicable record documented the DHA notification on the admission nursing chronological/notification progress note. The form document's the youth's medication, chronic conditions, and date and time of contact to the DHA and/or psychiatrist. None of the youth required emergency care during the admission process. An interview with the director of nursing indicated the nursing staff notifies the DHA by telephone of each youth's admission regardless of the youth's history or current health status. Additionally, if a youth has a chronic condition the youth will be placed on the weekly chronic list to see the DHA.

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

Seven youth medical records were reviewed, and each record contained a new Health-Related History (HRH) form completed for each youth on the day of admission. The program utilizes the most recent Department's HRH form and each form was completed by a registered nurse (RN). The designated health authority (DHA) reviewed each of the HRH forms and documented this review on each of the youth's Comprehensive Physical Assessment (CPA). The director of nursing verified this process in their interview and stated the nurse completes the HRH form during the initial nursing assessment on the youth's day of admission and when any new or significant medical event or changes occurs.

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

Seven youth medical records were reviewed and each of the records contained a Comprehensive Physical Assessment (CPA) completed within seven calendar days of the youth's admission by the designated health authority (DHA). The program utilizes the Department's standardized CPA form. All fields on the seven reviewed CPAs were completed by the DHA and included but not limited to the medical grade, body mass index, visual acuity field, Tanner stage, scalp/head, cardiovascular, and the most recent Tuberculosis Skin Test (TST). None of the youth presented with symptoms suggestive of active tuberculosis. None of the seven CPAs indicated the youth refused examination; however, in each of the seven records the two parts of the examination not completed because they were deferred by the clinician. All sections of the CPA were completed in full utilizing an "O" with no applicable with an "X". Reviewed records validated the Department's Problem List was updated for each youth throughout their stay, when applicable. The Infections and Communicable Disease form in each of the seven reviewed records documented TST results. An interview the director of nursing indicated the DHA completes a new CPA on each youth within seven days of admission and annually regardless of medical grade.

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

The program screens each youth for sexually transmitted infections (STI) on the day of admission by utilizing the Department's STI Screening form. Each of the seven reviewed youth medical records contained a STI Screening form completed on the day of admission. Each youth was referred for STI testing. Each record documented the test was ordered and administered on each youth's day of admission in accordance with protocols and physicians' orders. Test results were documented in each youth's medical record on the Department's Infectious and Communicable Disease (ICD) form. Referrals for all youth were documented on the Department's STI Screening form and on the ICD forms with one exception. One of the seven youth's STI Screening form did not have the "yes" box checked indicating the need for further testing; however, the testing order was documented in the physician orders and/progress notes. Lab results were filed in the lab results section of each youth's medical record.

Since March 13, 2019, the program contracts with and utilizes Metro Wellness and Community Centers for all human immunodeficiency virus (HIV) infection testing and counseling. The program provided a copy of the Metro Wellness counselor's 500/501 certification issued by the local Department of Health. The certified counselor conducts all testing and pre-test and/or post-test counseling on-site. A review of seven youth medical records validated each youth was offered an HIV test. Each youth's record contained a signed HIV Risk Assessment form and the Department's HIV Antibody Test/Youth Consent form. Three of the seven youth refused testing. All four of the remaining youth received pre-test and post-test counseling and each youth's results were in a sealed enveloped marked "confidential" which was placed in their medical record. Documentation of pre-test and/or post-test counseling was documented on each youth's Health Education Record. None of the youth signed a release for the results to be provided to other individuals nor was there evidence of information being shared. A review of the internal alert list and each applicable youth's Problem List verified the youth's HIV status was not listed.

An interview with the director of nursing indicated results are reviewed by the designated health authority and each sealed envelope is signed on the outside indicating their review. An interview with the director of nursing validated the program's practice. Seven youth were interviewed and each indicated they could ask for an HIV test.

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

The program has a policy and procedures indicating all youth shall be able to make sick call requests and have their complaints treated appropriately through an established sick call system. Each youth is oriented to the program's sick call process upon admission. Sick call care is provided by a registered nurse (RN) pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). Sick call hours are posted outside the clinic door noting the daily hours of 10:30 a.m. to 11:30 a.m. and 3:00 p.m. to 4:00 p.m., The program has a RN on duty ten hours a day, seven days a week. If there is not a licensed nurse on-site, the shift supervisor is to review all sick call requests as soon as possible and within four hours after the youth submits a request. The supervisor will then determine if the sick call requires immediate attention. The director of nursing and the DHA and/or designee are on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth complaining of severe pain including dental which a staff member is unfamiliar and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. Youth can obtain a blank sick call from a staff member or from the living unit's youth designated mayor. The mayor maintains a binder with blank sick call and grievance forms.

A review of seven youth records reflected five youth completed a Sick Call Request form at least once during their stay. In each instance, the RN documented the treatment and/or services provided to the youth during the sick call event on the Sick Call Request form. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. Two of the five applicable youth submitted a compliant which warranted a referral to the DHA. Reviewed records indicated all sick call complaints were documented on the Sick Call Index and Sick Call Referral Log. All completed Sick Call Request forms are filed in reverse chronological order in the progress note section of the youth's medical record. Room restriction/controlled observation has not been utilized at the program within the annual compliance review cycle; however, the program has a policy and procedures to address youth access to medical care while in restricted housing.

An observation of one sick call during the annual compliance review revealed the youth was escorted to the nurse's station by a Protective Action Response (PAR) certified youth care worker. The youth provided verbal and initialed consent for the regional monitor to observe the sick call process. The youth was seen by a RN in the medical clinic and the process was thorough and informative. The program's RN identified why the youth was there and requested the youth to initial the Sick Call form. The RN was knowledgeable of the youth's condition and offered an over-the-counter (OTC) medication to relieve the pain. The youth was educated on the reason for the pain and the OTC medication provided. Since the youth was having dental pain, the RN scheduled to the youth to see the DHA the following week. Seven interviewed staff

indicated nursing staff conducts sick call. Seven interviewed youth indicated they can be seen immediately or within one day from submitting a Sick Call Request form.

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

The program has a policy and procedures for the provision of episodic and first aid care. Procedures indicated emergency medical and dental care are available twenty-four hours a day. A review of fourteen staff training records revealed staff are currently certified in first aid and basic cardiopulmonary resuscitation (CPR) with automated external defibrillator (AED) training. The program provided documentation to confirm nursing staff facilitated an annual training for all program staff in the use of an epinephrine auto injector. All three licensed healthcare staff have a current certification in CPR with AED. The program has one AED which was observed and the instructions and guide were enclosed. The program's AED is stored in master control and accessible to staff. Instructions are also stored in the medical clinic for staff to obtain if needed. The AED's green light was blinking and operational upon observation. The battery and pad checks were completed for the AED and found the battery expires in July 2022 and the pads expires in May 2021. The batteries were installed on January 11, 2019 and the pads were installed in April 2019. The program has nine first-aid kits one on each of the three living units, one in the administration front office, one in the kitchen, one in maintenance area, and three in master control, two of which are used for transportation. During the annual compliance review, six sealed first aid kits were opened and three of them were missing at least one item. One kit was missing band aids, one kit was missing sterile saline, one kit was missing antiseptic wipes, rolled gauze and a CPR mask. Documentation indicates first aid kits and the AED are inspected weekly by a registered nurse (RN) and documentation was reviewed for the last six months to validate this practice. All emergency drills and trainings for direct care staff were reviewed for the past nine months and found all drills and trainings were completed, as required. An emergency drill was conducted every month for every shift over the last six months and once a quarter, the emergency drill included CPR/AED demonstration. Emergency numbers are inaccessible to youth and are stored in the front administration, master control, the kitchen, and in the medical clinic.

A review of seven youth medical records validated none of the seven youth were seen for episodic care by non-licensed staff. An additional three records were requested from the program; however, the program had one youth applicable since the last annual compliance review and the episodic care was provided by licensed medical staff. The health care staff member who rendered care was a registered nurse (RN). The nurse completed and documented the episodic care in SOAP (subjective, objective, assessment, and plan) format. All episodic care is documented on episodic care referral logs utilizing one form for each month, documenting all episodic and emergency care. A review of episodic care logs verified only one instance of care was rendered in the review cycle. A review of episodic and emergency care procedures was completed during the annual compliance review. Youth have access to emergency medical and dental care twenty-four hours a day, seven days a week.

Seven youth medical records were reviewed and four youth were seen for a total of five episodic and/or emergency care events. All examples of episodic care were provided by licensed healthcare staff. Each encounter was documented in the nursing chronological progress notes in standard narrative charting which includes all required elements. Off-site care documentation was filed in the youth's record and completed as applicable. All episodic care is documented on

episodic care referral logs, utilizing one form for each month, documenting all episodic and emergency care. Logs for the last six months were reviewed and no exceptions were noted.

A review of fourteen training records revealed all staff were trained in the use of an epinephrine auto injector. An emergency drill was conducted monthly on each shift. At least one drill in the last six months included CPR/AED demonstration and the use of an epinephrine auto injector. Seven staff were interviewed and indicated they could call 9-1-1 if there was a medical emergency. Seven youth were interviewed and questioned if they could see a dentist for tooth pain or see a doctor if needed. All youth indicated they could.

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

A review of seven youth medical records found four required referrals for off-site treatment (specialists or dentists) and none required off-site emergency care or first-aid. One of the four youth was over the age of eighteen years of age which only three youth required notification of care to a parent/guardian. One of the three parent/guardians was the Department of Children and Families (DCF) and the youth was sent off-site for routine dental examinations. A recommendation for invasive dental procedures has been recommended; however, despite several attempts by the program, DCF has not provided a court order approving the treatment. Notifications in all cases were made verbally and writing. All notifications were documented in the nursing progress notes and on the appropriate Department form. All four records contained the Department's Summary of Off-Site Care Consultation Report form, which was reviewed and signed by the designated health authority (DHA) upon the youth's return from off-site care. All records contained documentation of physician orders completed by the DHA upon their review of the discharge paperwork from the off-site visit. Follow-ups, referrals, and additional appointments were tracked and completed as documented in the youth's medical record when applicable. An interview with nursing staff reported the registered nurse calls the DHA after all off-site visits are completed and received telephone orders, if applicable and all the off-site care documentation is flagged in the youth's medical record and placed in the DHA's weekly review folder. Nursing staff also indicated they track any follow-up appointments through the healthcare services tracker.

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

The program maintains a policy and procedures to provide guidance to health services personnel in the areas of chronic illness monitoring and periodic evaluation time frame requirements. A review of seven youth medical records indicated all seven were identified with a chronic condition and each were put on the alert list, as required. All seven youth were classified with a medical grade of two through five. Seven youth were taking prescribed medication on an ongoing basis and there were no youth currently undergoing treatment for a physical health condition which included a body mass index greater than thirty. Each of the records documented updating of the Department's Problem List as changes occurred with one exception. The progress notes in one of the seven youth's medical records indicated the youth was treated by the designated health authority (DHA) for symptoms related to a communicable disease; however, testing to confirm this diagnosis was not ordered and this information was not

placed on the Problem List. The program indicates this diagnosis was not correct since lab testing was never ordered by the physician to confirm the diagnosis and they will have the youth see the DHA at their next on-site visit to have the youth properly tested. Reviewed records supported each youth received periodic evaluations as required and there was no indication of lapses in care or missed periodic evaluations for any of the youth. Six of the seven youth required monthly evaluations by the psychiatrist and each of the records contained the required documentation completed within the required time frame. The seventh youth stopped taking the medication once turning eighteen years of age. The nursing staff indicated once a youth is identified with a chronic condition at admission or by the DHA, the youth is placed on a tracker for monitoring and tracking of periodic evaluation due dates. The staff also indicated they meet weekly with the DHA and psychiatrist to review important issues pertaining to the youth. There was no indication of lapses in care or missed periodic evaluations in each of the reviewed records. All evaluations were completed on-site, documented in the nursing chronological progress notes, and treatment orders were clearly written. The executive director indicated medical issues pertaining to youth in the program as it relates to alerts, is discussed at the daily management meetings. An interview with the nurse and DHA reported youth identified with a chronic condition are placed on the medical tracker to ensure the DHA follows-up with each applicable youth. The psychiatrist indicated the youth are evaluated every thirty days.

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

The program maintains a policy and procedures to address medication verification and management. A review of seven youth medical records validated all seven youth were admitted into the program on prescribed medications. Reviewed nursing admission notes and Facility Entry Physical Health Screenings (FEPHS) documented the youth's current medications for each youth. Six of the seven records documented the designated health authority (DHA) and psychiatrist was verbally notified by telephone on the day of admission and orders to continue medication were received. In one record, the youth was only admitted on psychotropic medication; although, the nursing progress note did not indicate the DHA was called, the psychiatrist was. Each youth's order was current, valid, and documented on a physician's order form. Documentation in all records indicated the DHA or psychiatrist resumed the prescribed medication for each youth. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. When applicable, notification was made to the youth's parent/guardian and documented in the progress notes. The program's policy and procedures indicate trained non-licensed staff must verify medications when the youth are admitted to the facility and licensed healthcare staff are not on duty. The program may obtain emergency prescriptions from a local pharmacy, when necessary. Reviewed Medication Administration Records (MARs) validated the continuation of medications. A review of all MARs also verified there were no lapses in youth's medication regimen.

Each of the seven medical records were applicable for the youth having a change to medications or a new medication being ordered. In each instance, the practitioner order forms clearly documented the medication and dosage. An interview with the program's director of nursing reported all medications are verified with the records sent from the juvenile detention center or with the youth's parent/guardian. Verification is documented by the registered nurse (RN) in the chronological progress notes. Seven reviewed medical records found each youth had a MAR outlining over-the-counter medications (OTC) approved through the Authority for

Evaluation and Treatment (AET) form. All seven were administered OTC medications listed and not listed on the AET. In all instances, the medications were administered in accordance with the approved protocols and physician's order. Additionally, parental notification was sent in each applicable instance.

A review of each of the MAR revealed the program utilizes the standard Department Medication Administration record to document all medication and treatment. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. The medications are maintained in blister packs documenting the number of pills in each prescription order. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. All seven reviewed MARs supported the youth received the medication(s) as prescribed. The MAR clearly indicated the medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. There were no indications of lapses and/or errors in the medication administration. Nursing staff documented side effect monitoring on each MAR daily. The program has ten non-licensed supervisory level staff trained to assist in the delivery of medications when licensed staff are not on-site.

One of the seven records documented refusal of medication after the youth turned eighteen years of age. All refusals were clearly documented on the MAR and on refusal forms. The psychiatrist ultimately discontinued the medication. Observation of four medication administrations by nursing staff during the annual compliance review validated the nursing staff followed procedures and the Six Rights of Medication Delivery/Administration. All youth were escorted to the medical clinic by a direct care staff member. During an interview, the director of nursing confirmed the program does not have standing or pro re nata (PRN) orders for psychotropic medications nor do they have emergency treatment orders for psychotropic medication. Seven staff were interviewed regarding the administration of medication at the program and all reported the nurse administer the medications. Seven youth were interviewed and all seven stated a nurse administers their medication.

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

The program has a policy and procedures for the inventory and storage of all medications and sharps. The procedures include reporting criteria and procedures for inventory discrepancies. All medications are secured either in a locked medication cart and/or locked cabinets within the locked medical clinic, which is inaccessible to youth. The program contracts with 1st Choice Pharmacy for all medication services. The program maintains a perpetual shift-to-shift inventory for all controlled medications which is outlined in the program's policy and procedures for medication management. All controlled medications are maintained in a locked box within the locked medication cart locked in the medical clinic. All medications are obtained through the pharmacy and are in blister packs documenting the number of pills in each prescription order. Each youth's individual controlled medication inventory record is updated after each administration and inventory is conducted on each shift by two staff either the medical staff and/or a shift supervisor.

During an interview with the nurse, the nurse explained the process for disposal of expired or discontinued medications. Discontinued medications are either returned to the pharmacy for

credit, if applicable or destroyed on-site using the Rx Destroyer. All expired medication is destroyed on-site. Medications returned to the pharmacy are through the contracted pharmacy consultant. The program maintains a medication disposal binder for all medications destroyed on-site. The destruction of all medications on-site is witnessed and signed off on by two staff. All medications, sharps, and over-the-counter (OTC) medications are counted and/or verified weekly using a perpetually inventory. Syringes and sharps are stored in locked cabinets within the medical clinic. An inventory of three sharps, three OTC medications, and three controlled substances were conducted with the nursing staff and all counts matched the inventory. A review of the program's perpetual inventories of medications and sharps from the past six months were reviewed. There were no discrepancies noted. Observations found all medications were securely stored within the medical clinic. Oral medications are not stored with injectable or topical medications. The medical department has a secured refrigerator for the storage of medication only. Syringes and sharps are secured in a locked box within a locked cabinet.

The program had seventeen youth prescribed a controlled medication during the annual compliance review. Three controlled medications were randomly selected for inventory counts and all counts matched the ending inventory numbers. A review of the program's controlled medications shift-to-shift inventories for the six months prior to the review revealed the program did not have any noted discrepancies.

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

The program has infection control and exposure plan combined into one plan. The plan has procedures in place which includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as required by Occupational Safety and Health Administration (OHSA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The plan describes the process for needle stick post-exposure evaluation and indicates the executive director will establish a separate file for all documents who have experienced an exposure process for needle stick post-exposure evaluation. There were no incidents of needle stick post-exposure since the last annual compliance review. The review team was able to validate staff have access to Hepatitis B immunizations and protective equipment. The program's infection control and exposure control plan was updated in August 2019. The executive director reviewed the plan on August 1, 2019; however, the designated health authority (DHA) signature did not have a date of review. The previous version of this plan was signed and dated by both parties in March 2019. A review of the plan validated all required elements were included. A review of fourteen staff training records verified all staff were trained in infection control procedures. A review of seven youth medical records confirmed all youth were provided infection and exposure control training to include handwashing, prevention of blood borne pathogens, and prevention of communicable disease within seven days of admission to the program. Training to youth is documented in the youth's medical record and on the Health Education Record form. There were no instances where the local health department, CDC, and/or Central Communications Center should have been notified for an infectious disease.

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

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

Standard 5: Safety and Security

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

The program 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 with youth. A review of the logbooks indicated the program follows the posted schedule. There were notations of one staff being assigned to Dorm One during sleep hours which has a staff ratio requirement of one staff to twelve youth; however, this dorm has sixteen youth assigned. The logbook review indicated there were six to seven staff assigned to the shift, meeting the facility wide staffing ratio according to the contract. Throughout the annual compliance review, staff were observed to be posted in appropriate positioning, 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 youth 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. Seven 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) utilized 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 of each dorm. 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 to advance through the levels. 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 called a phase sheet. 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. The assistant executive director, director of case management, case managers, director of clinical services, therapist, and a member of the floor staff review every phase sheet to identify youth who received phases (consequences) for

engaging in inappropriate behaviors and having the treatment team work together to identify how to best address the youth's behavior. During this meeting, they ensure phase sheets are completed correctly, consistent, and are fair. They can provide any other input not captured on the phase sheet or input of the situation. Seven interviewed staff indicated an understanding of the BMS and received training. All seven staff training records reflected they received BMS training on the specific BMS model used at the program. All seven interviewed youth indicated they understood the BMS and the difference between each level and how they move from level to level. Seven youth interviews also reflected youth are familiar with the type of rewards and incentives. The executive director interview indicated the BMS is a four-level system which addresses five 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 phase 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 of the annual compliance review indicated there are no youth being secured behind locked doors or in rooms. The program uses several methods to ensure the BMS is utilized fairly and effectively, which includes monitoring point phase sheets during phase meeting daily except for Tuesdays, treatment meetings, discussing the use of phase sheets 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 disagrees with points assigned or lost, the phase sheets are reviewed by the assistant executive director during the phase meetings. Seven 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 indicating 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 reflected the required qualifications of staff whose job functions includes implementation of the BMS. Seven interviewed staff indicated room checks are conducted between eight and ten minutes when youth are in their rooms for sleeping purposes.

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 by staff entering the time of the check on the ten-minute check sheet. The program utilizes thirty-eight cameras to maintain surveillance of the facility and all cameras were functional during the annual review. Review of eight hours of ten-minute checks on video coverage for various days, times, and shifts revealed staff observed youth in rooms which did not exceed ten minutes and were documented in real time with one exception on November 25, 2019. A check was observed at the time of 10:30 p.m. with the next check occurring at 10:59 p.m., a twenty-five-minute lapse between checks. Seven interviewed staff indicated 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 feasible after order has been restored.* *The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.*	

The program has a policy and procedures addressing youth census, counts, and tracking. The main facility count is maintained on a dry erase board located in master control and the facility logbook. A review of the facility logbook indicated headcounts are completed 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 facility logbook. Informal counts occur after every movement to and from class, group, codes, and meals which is documented in the facility logbook. Facility logbooks include 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. Seven staff interviews indicated counts are conducted at the beginning of shifts, 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, emergency situations, special instructions, count 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 which is primarily maintained 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 five Central Communications Center (CCC) incidents and all five were found in the 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 an identifying tag and the appropriate number of keys assigned to each ring sketched on the tag. A team member observed the key rings to be clearly labeled and secured in master control one of the two dedicated lock boxes. One lock box is reserved for restricted and medical keys and the other box is for personal and miscellaneous keys. An interview with shift supervisor, who was stationed in master control for the week 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 shift supervisor indicated there were no reports of lost or missing keys in the past six months. The shift supervisor also confirmed restricted keys are the nursing staff is the only staff with access to the medical lock 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 a locked closet located in the case management area. According to the shift supervisor, 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 revealed there were three instances where the key log had write-overs and there were two instances where the key log

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

The program 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. Contraband items have been identified in the youth and parent/guardian handbook which includes consequences if youth are found with contraband. There is a contraband list posted in the lobby and cafe for youth and visitors. It identifies what is considered contraband such as sharps, escape paraphernalia, tobacco products, metals, e-cigarettes, cell phones and smart watches, money, and non-facility issues keys. 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. All incoming and outcoming mail is logged in the mail logbook and searched in the presence of the youth to control contraband being introduced to the facility. 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 the 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 the 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. An 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 the youth politely. Searches were conducted by staff of the 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. Seven staff were interviewed and indicated all searches are done by same gender as youth for all movements throughout the day. Full body visual searches are done for admissions or youth returning from off-site activity. Seven youth were interviewed and indicated searches are done when returning from off-site, after outings, meals, visitation, recreation, and during work details.

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

The program has 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, a first aid kit, and a safety screen separating the driver and the youth. First aid kits are stored in facility until needed for transport. Transport vehicles are equipped with appropriate number of seat belts and doors not operable from inside the youth area of the vehicle. The program had one transport scheduled during review period and observation indicated transporting staff checked the oil pressure, coolant levels, break fluids, tire pressure, lug nuts, doors, door locks, seat belts, and debris laying on the floor. A 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. Seven staff and youth were interviewed and reported they all wear seatbelts. Staff also indicated they are provided a cell phone while on transports. A review of the annual safety inspection for the program's two vehicles were current. One van received an annual inspection on December 4, 2019, and the mini-van received an annual inspection on March 6, 2019. The program has a preventative maintenance binder which contains invoices of repairs, maintenance, and safety inspections which verification indicated documentation of deficiencies and corrections completed.

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

The program has a policy and procedures to address the transportation of youth. The program ensures all transport drivers have a current driver's license. All seven staff interviews indicated program cellular phone is provided for communication during all transports and personal vehicles are not used to transport youth. The observed youth transport included two staff both male with one male youth. The program's staff to youth ratio of one to five for transports was met. Staff of the same gender as the youth searched and applied ankle restraints and handcuffs on the youth prior to the transport. A random check of the parking lot revealed vehicles were

locked when not in use as well as vehicles in the delivery sally-port. Program provides at least two staff when transporting youth. Interview with seven 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 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. The weekly audits are reviewed by the assistant executive director. The program utilizes a security audit and safety inspection form for documentation of weekly audits and presenting deficiencies which are maintained in the weekly safety inspection binder. The weekly safety inspections binder was reviewed spanning the last six months prior to the review and it supports the program consistently completed weekly facility inspections completed by the assistant executive director or physical plant manager and reviewed by the executive director on the same day as the inspection. An interview with the executive director indicates there is a clear process regarding the identification, tracking, and 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 room and physical plant manager office which are as one and is located behind the kitchen outside on the property. The tool room was found to be locked and secured. There were no prohibited tools observed during the tool shed and tool office inspection. Class A tools were maintained in the locked tool room and 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 daily inventory sheets which were accurate and current being maintained in a tool binder which includes colored pictures of the tools. A review of seven staff pre-service and seven staff in-service records reflected t staff are properly trained on tool management protocols. Seven youth were interviewed and indicated they only use mops and could not utilize additional tools. Seven 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 seven youth records also confirmed youth are given an assessment to determine the level of tool access and training on the use of class B tools during orientation. Youth are not allowed to use class A tools or assist the physical plant manager with activities requiring the use of such tools. Additionally, youth do not have access to the kitchen class A tools nor do they use these tools during the program's culinary arts program.

Seven youth and seven staff were interviewed and indicated youth do not have access to any tools without supervision and only use class B tools.

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

The program has a policy and procedures in place to ensure guidelines are established to govern outside contractors which include information on tool control and restrictions. A review of the visitor sign-in logs for the past six months from May 1, 2019 to December 13, 2019 indicated there was a total of five vendors of which all five were paid vendors. A review of all five invoices found all invoice dates of service matched the visitor sign-in and sign-out log and a list all tools and supplies brought into the program. All contractors are provided a written notification and guidelines for outside contractors which includes all the expectations upon arrival and departure from the program. On the back of the form, there is a section for the contractor to list all tools being brought into the facility and removed when the contractor leaves. The form is signed by both the contractor and the program staff inventorying the contractors' tools.

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 six months from May 1, 2019 to December 12, 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 six months. The types of drills documented were flood, fire, severe weather, active shooter, hostage, escape and evacuation. An interview with the executive director confirmed, they have at least three fire, safety, and evacuation drill monthly. Seven staff were interviewed and confirmed fire, safety, and evacuation drills were conducted on a monthly basis. Inspection of facility fire extinguishers verified extinguishers are inspected annually. Seven 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. *A residential commitment program shall establish and maintain critical identifying information and a current photograph which are easily accessible to verify a youth's identity, as needed, during his or her stay in the program.*	

The program has a coordinated Continuity of Operations Plan (COOP). The plan and all plan annexes are in compliance with the Department of Juvenile Justice (DJJ) requirements. The plan was submitted by the program and reviewed by the regional director on April 24, 2019 and signed by the DJJ representative on April 24, 2019. The executive director confirmed the COOP is posted in master control and the executive director's office. The COOP is accessible to all staff and is posted in the staff breakroom and conference room. Emergency food supplies are stored in the kitchen storage room which is in a storage container on-site. The COOP binder also included critical identifying information such as youth's face sheet and admission card which contains all the required information. Seven 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 cabinets located outside the facility next to the program's physical plant manager's office. Chemicals used on a daily basis are secured in the kitchen in a locked supply room or in the housekeeping storage room. 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. The program director, assistant program director, housekeeping, and physical plant manager are the only staff with access to the chemicals. The program maintains a binder with copied pictures of all the chemicals on-site with an attached SDS for each item. A review of the past six months of chemical inventories and daily use sign-in and sign-out logs confirmed chemicals were inventoried daily, weekly, and are being tracked and monitored by the physical plant manager and assistant program director.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance

The program shall maintain strict control of flammable, poisonous, and toxic items and materials.

Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.

The program shall establish and implement cleaning schedules, a pest control system, a garbage removal system, and a facility maintenance system which shall include maintenance schedules and timely repairs based on visual and manual inspections of the facility structure, grounds, and equipment, which shall be conducted bi-weekly, monthly, quarterly, semi-annually, yearly, and every three years, as prescribed in the Preventive Maintenance Checklist (RS 123, February 2019.

The program 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 cabinets located outside the facility next to the program's physical plant manager's office. Chemicals used on a daily basis are secured in the kitchen in a locked supply room or in the housekeeping storage room. 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. The program director, assistant program director, housekeeping and physical plant manager are the only staff with access to the chemicals. The program maintains a binder with copied pictures of all the chemicals on-site with an attached SDS for each item. A review of the past six months of chemical inventories and daily sign-in and sign-out logs confirmed chemicals were inventoried daily, weekly, and are being tracked and monitored by the physical plant manager and assistant program director. Seven youth were interviewed and all seven indicated they do not utilize any chemicals or cleaning products.

5.20 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance

The maintenance personnel, or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste, shall be responsible for disposing of hazardous items and toxic materials.

The program has a policy and procedures in place to ensure the physical plant manager has the safety equipment and procedures for handling and disposing of hazardous waste and/or solid waste and toxic materials. Hazardous material is maintained inside a marked locked cabinet outside the facility next to the physical plant manager's office. The program keeps a running inventory of chemicals, the use of chemicals, and safety data sheets of each stocked chemical on-site according to standard requirements. The executive director and the physical plant manager stated the physical plant manager disposes 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). A review of the program's tracking sheet of disposal noted the last disposal of such chemicals occurred in July 9, 2019.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures 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 telephone log for each youth and is maintained in a binder. Both parent/guardian and youth are provided handbooks outlining ongoing communication. All incoming and outgoing mail is screened by program staff in front of the youth to ensure positive communications with correspondents.

The program holds visitation every Saturday and Sunday from 1:00 p.m. to 4:00 p.m. Alternate visitation arrangements are provided as needed and are set up between the youth's parent/guardians and program administration. All telephone calls are recorded in the youth's telephone log with the number, time the call started and ended, and person called. Seven youth

were interviewed and all stated they are allowed to send mail, make telephone calls, and participate in visitation.

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

The program has a policy and procedures in place for controlled observation and the policy addresses inspecting and searching of the room and youth prior to placement in controlled observation. Since the last annual compliance review, the program did not place any youth into controlled observation; therefore, there was no documentation to review for compliance.

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

The program has a policy and procedures in place outlining the program's process for placing a youth in controlled observation. Since the last annual compliance review, the program did not place any youth into controlled observations; therefore, there was no documentation to review for compliance.

5.25 Controlled Observation Safety Checks Release Procedures	Satisfactory Compliance
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 has a policy and procedures in place for controlled observation and the policy addresses safety checks and release procedures. Since the last annual compliance review, the program did not place any youth into controlled observations; therefore, there was no documentation to review for compliance.

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

The program has a written policy and procedures to ensure each youth has a safety plan. Plans are developed to identify warning signs, youth baseline behaviors, crisis recognition, coping strategies to include people and health environments, intervention strategies, and debriefing preferences. A review of seven youth mental health records indicated each youth initial safety plan was jointly prepared with the youth, parent/guardian, clinical staff, and contained the required topic areas. All seven safety plans were completed within the required fourteen-day time period. Each reviewed plan incorporated recommendations from collateral sources and previous clinical assessment. Each safety plan was reviewed monthly during treatment team meeting, signed by staff who have contact with youth, and updated as required. Seven youth were interviewed and each stated they were involved in the development of their safety plan.