STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

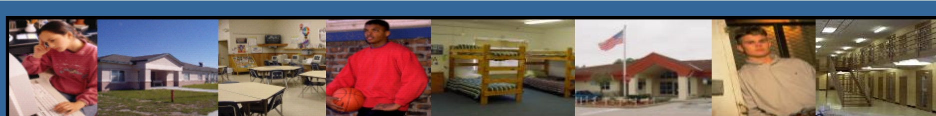
PROGRAM REPORT FOR

Columbus Youth Academy

Sequel Youth and Family Services, LLC

(Contract Provider)
9502 East Columbus Drive
Tampa, Florida 33619

Review Date(s): April 23 - 26, 2019



PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Stephanie Lobzun, Office of Program Accountability, Lead Reviewer (Standard 1)
Bacchus, Jamila, Office of Program Accountability, Regional Monitor (Standard 5)
Clay, Melinda, Youth Opportunity Investments, Director of Case Management (Standard 2)
Goldstein, Felicia, Office of Program Accountability, Regional Monitor (Standard 4)
Nelson, Amanda, Office of Program Accountability, Regional Monitor (Standard 3)
Rose, Rowena, DJJ Office of Education, Education Coordinator (Standard 2 – 2.16, 2.17, 2.18)
Sheffer, Paul, Office of Program Accountability, Regional Monitor (Standard 3)
Taylor, Canitha, Office of Program Accountability, Deputy Regional Supervisor (Interviews)
Wilson, Sherri, Office of Program Accountability, Technical Assistance Specialist, (SPEP)

Program Name: Columbus Youth Academy
Provider Name: Sequel Youth and Family Services, LLC
Location: Hillsborough County / Circuit 13
Review Date(s): April 23-26, 2019

MQI Program Code: 1442
Contract Number: 10476
Number of Beds: 50
Lead Reviewer Code: 140

Methodology

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

Persons Interviewed

☒ Program Director
☒ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
1 # Case Managers
3 # Clinical Staff
1 # Food Service Personnel
2 # Healthcare Staff
0 # Maintenance Personnel
3 # Program Supervisors
7 # Staff
7 # Youth
1 # Other (listed by title): **Assistant Program Director; Lead Teacher**

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	Satisfactory
2.04	Classification Factors, Procedures, and Reassessment for Activities	Satisfactory
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	R-PACT Assessment and Reassessments	Satisfactory
2.08	Youth Needs Assessment Summary	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Satisfactory
2.10	Performance Plan Revisions	Limited
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	Limited
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	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Room Restriction/Controlled Observation	Satisfactory
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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

Program Overview

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 provider took over the program from another provider on April 2, 2018. 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 the Adolescent, Life Skills Training, the adolescent coping 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 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, a full-time registered nurse, part-time registered nurse, and a full-time medical clerk. 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 has recently added a music program led by one of the licensed therapist. The youth learn to play the guitar and keyboard. The initiative is an alternative method to enhance the youth's life skills and to help the youth develop coping skills and express feelings through music.

- Columbus Youth Academy recently added the H.O.P.E (Holding onto Positive Expectations) step team, headed up by the program's transitional service manager. The initiative was created to help the youth learn more about the importance of discipline, togetherness, and team work. The step team has performed for the facility staff, as well as family and friends during the quarterly family day events.

- On January 26, 2019, the program volunteered with Women Helping Others of Tampa Bay at the Borrell Park and helped the homeless and less fortunate by serving hot food, handing out drinks, passing out essential items, as well as clothing. The youth helped serve approximately forty people and make a difference in someone else's life, while experiencing how good it feels to give back to others.

Standard 1: Management Accountability

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

The program has a policy and procedures in place indicating a live scan background screening will be completed on all employees and volunteers. The program's policy further states all staff and volunteers will be rescreened after five years from the employees' date of hire and repeat the re-screening process every five years thereafter. A review of the program's staff roster indicated the program had thirty-one new employees hired since the last annual compliance review. A review of the Florida Agency for Health Care Administration website, also referred to as the Clearinghouse, revealed thirty employees received an eligible rating prior to working with youth. The thirty-first staff member's record revealed the staff's hire date with the program was listed as November 13, 2018; however, the staff's background screening was not approved by the background screening until December 19, 2018. There were nineteen volunteers used by the program since April 2, 2018. All the volunteers received an eligible background screening prior to working with the youth at the program. All employees and volunteers were listed on the program's roster in the Clearinghouse website. There was evidence in all thirty-one employee records the hiring authority reviewed the Central Communications Center system, Staff Verification System and reviewed the Florida Department of Law Enforcement automatic training management system as part of the pre-employment background screening process. The program uses an ergometrics and applied personnel research testing company to perform a pre-employment impact test on all direct care staff being considered for employment. A review of the thirty-one employee records revealed twenty of the employees were being hired for a direct care position and nineteen of the staff received the ergometrics testing. The program could not locate the ergometric testing for one of the newly hired staff. The nineteen applicable employee records revealed fourteen employees passed the pre-employment impact test prior to hire. There were five staff who did not pass the pre-employment test; however, an interview with the human resources staff indicated the program does not disqualify a person from being hired if they do not pass the pre-assessment testing. The human resources staff indicated a person's work history, prior experiences, the interview, and the pre-assessment results are all considered during the hiring process. The program submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit on January 15, 2019. The Hillsborough County School Board submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit on January 23, 2019.

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

The program has a policy and procedures in place indicating all staff and volunteers will be re-screened after five years from the employees' date of hire and they will repeat the re-screening process every five years thereafter. A review of the program's volunteer and staff roster indicated there were six staff and two volunteers who required five-year re-screenings since the last annual compliance review. A review of the Clearinghouse website revealed five staff received an eligible five-year re-screening prior their five-year hire date anniversary. The sixth staff's five-year re-screening was required by February 9, 2019; however, it was not completed until April 9, 2019 and was fifty-nine days late. During the debriefing process, the program acknowledged the staff's re-screening was conducted late. A review of the two volunteers background screening revealed they received an eligible background screening in March 2014; however, a review of the Background Screening Unit (BSU) website revealed no five-year rescreening for either volunteer had been submitted as required by the Department's background screening policy. During the debriefing process, the program advised the team the volunteers are only in the program for one to two hours once a month and the program's interpretation of the Department's BSU policy indicates all volunteers who are in the facility less than ten hours a month are not required to have a background screening. The program was advised during the review the Department's BSU policy stipulates volunteers who are on-site on a regular basis and more than once a quarter are required to be background screened.

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

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

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

The program has a policy and procedures for the provision of an abuse-free environment and unhindered access to report allegations of abuse. The program's policy states the program will comply with and support the Department's policy on abuse reporting, all allegations of child abuse or suspected child abuse will be immediately reported first to the Florida Abuse Hotline and second to the Department's Central Communications Center (CCC) within two hours of the incident or knowledge of the incident. The program's policy further indicates youth who are eighteen years of age or older will report alleged abuse to the Department's CCC. The program also has a policy regarding employee code of conduct, which indicates employees will comply with the providers standards of conduct. A review of the program's code of conduct provides employees with the providers expectations for staff to interact with youth and others in a manner which promotes a positive and professional environment. A review of fourteen employee records indicated each employee signed, reviewed, and agreed to abide by the program's code of conduct during the hiring process. The program had postings of the CCC number, and Florida Abuse Hotline number throughout the facility. The postings were observed during the facility tour in each of the three youth dormitory areas and cafeteria. An interview with the program director indicated it is the program's policy to immediately allow youth to access a telephone when they request an abuse call. The program staff will notify a supervisor who will then take the youth to the administration area or the case management office to make the phone call, which allows the youth privacy to make the call. A review of the program's internal investigations and incidences revealed there was one substantiated allegation of abuse since the last annual compliance review. The program immediately removed the employee from contact with youth, investigated the allegation and subsequently terminated the employee. During the review, the review team did not observe any physical, emotional, or psychological abuse while on-site. Interviews with seven youth indicated they all felt safe in the program. One youth further indicated they like it at the program and another youth indicated they rather be at this program than any other program. The seven interviewed youth also indicated they have never been stopped from calling or reporting abuse to the Florida Abuse Hotline. One youth further indicated they really do not need to call abuse because staff are respectful. All seven interviewed youth indicated staff are respectful to them when they speak to them. Five of the interviewed youth indicated they had never heard a staff use curse words when speaking to them or other youth. Two youth indicated they had heard staff use curse words, but the use of

the words was never directed at them or another youth. Six of seven interviewed staff indicated they had never seen or heard another staff use profanity, threats, intimidation or humiliation when interacting with youth at the program. The seventh staff indicated they had heard staff use curse words in the presence of youth, but the profanity was never directed at the youth. All seven interviewed staff indicated they had never observed a co-worker tell a youth they could not call the Florida Abuse Hotline. Seven staff were interviewed about the program's abuse policy and all staff indicated they are required to allow the youth to make a call to the Florida Abuse Hotline. Four of the seven staff further indicated they are to notify their supervisor the youth has or would like to make an abuse call. One of the seven staff also indicated they would notify the program director the youth made or would like to make an abuse call. Two of the staff further indicated they would have their supervisor make the call with the youth to the abuse hotline. During the interview with the program director they indicated the employee code of conduct specifies what actions will be taken in the event an employee violates a policy. The director further indicated disciplinary action will be administered using processive discipline; however, infractions which are critical can result in immediate termination, if abuse, threats, or profanity are used toward a youth. The director further indicated an internal investigation would be initiated by the facility when any violation is suspected, and appropriate notifications will be made. The director also indicated staff would be placed on suspension pending the results of the investigation and if allegations of abuse are verified those actions would constitute termination of the employee. The program director indicated all staff are obligated by law to report allegations of abuse. The director further indicated youth within the program have unimpeded access to contact the abuse hotline. The director also stated after an allegation is reported the program director and/or designee are immediately notified and the CCC will be notified within the required two-hour timeframe.

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

The program has a policy and procedures in place outlining and identifying behavioral expectations for staff and designate an employee dress code which is in line with the company standards. The policy further indicates program staff will adhere to a code of conduct and staff who do not comply with the agencies standards of conduct and dress code may be subject to coaching/training, or disciplinary action. Since the last annual compliance review, the program had one allegation of staff on youth abuse, one staff violation of policy, and one staff violation of improper supervision, which was reported to the Central Communications Center (CCC) in two different reports. One of the incidents was also reported to the Florida Abuse Hotline. The one CCC report which resulted in the violation of policy and improper supervision involved two different staff. The program provided documentation to support the program director investigated the allegation and each staff was found to be in violation of program policy. Each staff member received a coaching/training session as a disciplinary measure to ensure staff are aware of the program's policies and expectations. The second CCC was also reported to the abuse hotline for alleged staff on youth abuse. As soon as the program was made aware of the allegations against the staff, the staff member was removed from contact with youth and program administration started an investigation. The program's investigation, along with the Department's investigation found the staff member used excessive force when restraining a youth and the staff also was found to have hit the youth. The program's documentation indicated the staff member abandoned their posted when confronted about the allegation and

the program terminated the staff, with an ineligible re-hire rating. During the interview with the program director, they indicated they had one staff terminated for allegations of abuse toward youth. The director also indicated all staff are made aware of the Florida Abuse Hotline and CCC reporting procedures during new hire training, in-service trainings, and during general staff meetings. The director further indicated youth are made aware of the Florida Abuse Hotline and CCC reporting information during their orientation to the program, by viewing postings throughout the facility and they all receive a copy of the information in their youth handbook.

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

The program has a policy and procedures in place indicating the program will comply with the Department of Juvenile Justice's policy on incident reporting. The policy indicates the Central Communications Center (CCC) will be notified as soon as possible, but no later than, two hours after any reportable incident occurs or within two hours of the program learning of the incident. A review of the CCC database indicated the program had one incident reported in the six months prior to the annual compliance review. A review of the one incident indicated it was reported to the CCC within two hours of the program's knowledge of the incident. The incident was labeled as a medical incident and was required to be documented in the program's logbook. A review of the applicable program logbook revealed the incident was documented accurately. Four additional CCC incidents were reviewed for compliance with the minimum sample size of five CCC incidents. All additional incidents were reported to the CCC within the required two hour timeframe. Two of the four incidents were labeled as medical incidents, one was typed as a program disruption and one was labeled as a complaint against staff and a youth behavior incident. Three of the four additional CCC reports were required to be logged into the program's logbook and all three were found in the logbook on the appropriate date. A review of the CCC database for the six months prior to the review revealed there was one CCC report, and there were eight reported in the same time-period in 2018; therefore, there was a decrease in the number of reportable incidents to the CCC from one year to the other. 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.

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 in place addressing Protective Action Response (PAR) and physical interventions. The policy indicates staff at the program will use appropriate counseling, verbal intervention, and de-escalation techniques prior to resorting to the physical interventions. The policy further states the use of PAR will be used as a last resort and must follow the PAR escalation matrix. There were five PAR incidents in the six months prior to the annual compliance review, which is a decrease from the same time-period as last year where the program had six PAR incidents. All five PAR reports were reviewed for compliance with the

indicator and Florida Administrative Code. All reports had narratives from each staff member involved in the incidents and the narratives were completed by the end of the staff members workday. None of the reviewed PAR incidents include the use of mechanical restraints and there were no allegations of abuse made by the youth or injuries to the youth or staff, which were required to be called into the Central Communications Center. All reports were reviewed and signed by a certified PAR instructor, the acting supervisor on duty at the time of the incident, and the program director/designee. All PAR techniques were found to be deemed necessary by the program staff who reviewed each incident. All incidents had documentation a post-PAR interview, which was completed within thirty-minutes of the incident and documented on the PAR reports. None of the reviewed PAR incidents required a medical review since there were no documented injuries to the youth or staff. The program maintains a PAR binder, which is where a copy of the monthly PAR report is maintained along with the original PAR reports. The program sends their monthly PAR report to residential services by the fifth of each month. An interview with the program director indicated the program continuously places an emphasis on utilizing verbal de-escalation techniques when dealing with escalated situations/incidents. The program director also indicated physical intervention is always used as a last resort. They also indicated all PAR related incidents are reviewed by the assistant program director and/or the program director. A PAR review committee is held following each PAR incident. The staff and youth involved in the incident along with members of the treatment team are present at the meeting. The purpose of the meeting is to process the incident with the youth to avoid future PAR related incidents.

The program has a PAR plan, which was reviewed and approved by the residential regional director on January 14, 2019 and by the Department's bureau of staff development and training on January 6, 2019. The program's PAR rate during the annual compliance review period was 0.75, which is below the statewide average of 1.57.

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

The program has a policy and procedures in place indicating the program will implement a training plan to ensure all program staff completes pre-service training with a total of 120 hours, within thirty days of hire. The program submitted, in writing, a list of pre-service trainings to the Department's Office of Staff Development and Training for the fiscal year of 2018, which was approved on January 30, 2018. A review of seven staff training records indicated all staff completed their 120 hours within the first thirty days of employment. All seven staff received all trainings outlined in the Florida Administrative Code, 63H-2.003. All seven staff received training in Protective Action Response, cardio-pulmonary resuscitation, first aid, automatic external defibrillator, professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting and Prison Rape Elimination Act prior to being in the presence of youth. There were four of the seven staff which did not have the contractually required training of stress management. There were three of the seven staff which did not have the contractually required training in restorative justice. There were two of the seven staff which did not have the contractually required training in human trafficking.

1.08 In-Service Training	Satisfactory Compliance

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

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

The program has a policy and procedures in place indicating the program will implement a training plan to provide all staff with in-service training annually. In-service training begins the calendar year after a staff person completes their pre-service training. The policy further indicates all direct care staff will complete a minimum of twenty-four hours of in-service training each calendar year. A review of seven staff training records indicated all staff have training in first aid, cardiopulmonary resuscitation, automatic external defibrillation, professionalism and ethics, Prison Rape Elimination Act, updated training in Protective Action Response, 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. Four of the seven reviewed staff were supervisory staff and each received eight hours or more hours of required supervisory training on the topics of management, leadership, personal accountability, employee relations, fiscal, and communication skills. All instructors and facilitators of the training provided to staff were qualified to deliver the specific training. The program submitted, in writing, a list of in-service trainings to the Department's Office of Staff Development and Training which was approved on January 30, 2018 for the fiscal year of 2018.

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 in place regarding the program's grievance process. The policy allows youth to grieve, in writing, the actions of program staff or the youth's peers, or conditions and/or circumstances of care and treatment which are a violation of their rights. The program's grievance process has three phases. The initial phase of the process is the informal phase, which is where the youth speaks to the staff or peer they are having a problem with and use the informal request to talk form at the time the grieved situation occurs and try to work out the situation informally. The request to talk forms should be placed into one of the program's grievance boxes, which are located on each youth dormitory. The program's policy indicates the grievance boxes are checked each shift by the shift supervisor. The second phase of the program's grievance process is for the youth to submit a written grievance and place the grievance in the grievance box on one of the dormitories. The grievance boxes are checked daily on each shift, and the grievances are logged into the master grievance log to ensure the grievance process timeframes are met. Once the grievances are logged the grievances are given to the supervisory staff who will address the grievance with the youth. Grievance forms are located on the staff desk in each of the program's three youth dormitories. The next level supervisor or shift supervisor will review and investigate the youth's grievance and render a written decision to the youth within four days of receiving the grievance. The decision and any action taken will be reviewed with the youth who filed the grievance. If a youth is not satisfied

with the supervisor/second phase of the grievance process the grievance will be forwarded to the program's assistant program director or designee, which is the third phase of the process. During this phase of the process the grievance will be reviewed, a written response will be provided and discussed with the youth within twenty-four hours of receiving the grievance from the supervisory phase. If the problem is still not resolved the youth may request a review by the program director, who will provide the youth with a decision in writing within forty-eight hours of receiving the grievance form from the assistant program director. A review of seven in-service training records and seven pre-service training records revealed all staff received training in the program's grievance process. A review of the program's grievance binder indicated the program maintains twelve months of grievances within the binder. The program had no grievances filed by the youth in the six months prior to the annual compliance review; however, the program did have three grievances filed since the last annual compliance review and those grievances were reviewed for compliance. All three reviewed grievances indicated all were handled in the formal phase of the grievance process. Each youth signed the grievance, indicating they agreed with the outcome of the grievance in the formal phase of the process and did not want to appeal the response from the supervisor. An interview with seven staff indicated all staff knew where grievance forms are kept in the program, they knew youth can request assistance in completing grievance forms, they knew the program's process has three phases, and there are timeframes for each phase, they knew supervisors review grievances, and they knew grievances are reviewed by the program director. One of the interviewed staff further indicated a youth may write a grievance and place it in the locked box for the supervisor to check and begin the process. A second interviewed staff further indicated if a youth feels they have been treated unfairly they can request to write a grievance. Interviews with seven youth indicated six of the youth knew where the program maintains grievance forms, they knew the grievance process has three phases and grievances must be handled within specific timeframes. The six youth also indicated they could seek assistance from staff in filling out a grievance form, if necessary. The seventh youth indicated they never had to fill out a grievance form. An interview with the program director indicated all youth have access to grievance forms, which are maintained on each dormitory. The youth can submit grievances by placing a completed form into the grievance box on the dormitory. The director indicated the first phase of the process is for the youth to fill out the grievance. The second phase is the youth meeting with the facility grievance officer. The final phase includes a review by the assistant program director or a meeting with the youth and the program director, if the youth is not satisfied with the resolution proposed by the grievance officer.

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

The program facilitates Thinking for a Change (T4C), an evidence-based model; Impact of Crime (IOC), a practice with demonstrated effectiveness; Pathways, a practice with demonstrated effectiveness; Living in Balance (LIB), a promising practice; and Young Men's Work, a practice with demonstrated effectiveness. The program currently has a total of twelve employees trained in one or more of the five delinquency interventions facilitated at the program. A review of the staff training records revealed three staff are trained to facilitate IOC; one staff is trained to facilitate Young Men's Work; seven staff are trained to facilitate Pathways; three staff are trained to facilitate LIB; and five staff are trained to facilitate T4C. Seven of the

twelve facilitators are licensed professional, one has master's-level degree, two have a bachelor's-level degree, and two have a high school diploma. A review of each facilitators employee records confirmed all facilitators had experience working with adult and/or juvenile offenders prior to being hired and/or trained to facilitate delinquency interventions. A review of the program's contract indicates the program has staff trained to provide all their required evidence based delinquency interventions, as well as their mental health and substance abuse groups. A review of the group sign-in sheets confirmed the program is providing all the interventions and groups listed in their contract. A review of seven youth case management records, seven youth clinical records, and group sign-in sheets indicated the reviewed youth have either participated in or completed one or more of the delinquency interventions listed above. A review of the same seven youth's performance plans revealed each youth's plan contains a goal for the youth to complete one or more delinquency intervention group, and the plans further indicate at least one of each youth's top criminogenic needs will be addressed by their participation in the interventions.

A review of the program's posted schedule, as well as a review of the program logbooks indicate at least sixty percent of the youth's awake hours are filled with structured, planned programming and activities. An interview with the program director indicates the facility management team meets and discusses potential staff members who have the skill set to facilitate groups. The management team will then evaluate the staff's education level and years of experience working with at-risk youth prior to selecting the staff member as a facilitator. Other considerations include the staff members rapport with the youth, verbal communication skills, and written communication skills.

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

The program provides youth with interventions and instruction focused on developing life and social skills. The program's case management and mental health staff provide life skills groups and instruction to the youth at the program. The program provides evidence-based curricula entitled Skillstreaming, Thinking for a Change (T4C), Life Skills training (LST), and Young Men's Group.

An interview with the designated mental health clinician authority (DMHCA) indicated the program provides life skills training groups to the youth which are reflected in the youth's treatment plans and the groups address issues such as emotional regulation, coping mechanisms, and anger management. In addition to the life skills training groups, the program provides Skillstreaming and the adolescent coping groups. The DMHCA also indicated the program educates the youth during the monthly advisory board and community meetings about conflict resolution, dealing with difficult people, and living in the community. The program provides the above listed curricula in a group setting and groups are held seven days a week. According to the program's schedule groups are held Monday through Friday at 2:10 p.m. to 3:00 p.m. The weekend schedule indicates: groups are held from 8:00 a.m. to 12:20 p.m. with a total of four separate groups being held during those times 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 each youth is currently participating in at least one of above listed groups. The program had twelve different staff members trained to provide one or more of the curricula since the last annual compliance review. A review of the twelve staff

training records revealed each staff received training in the curricula they provide to the youth. An interview with seven youth indicated all the youth are enrolled in a group. Three youth specifically stated they are currently participating in IOC; all interviewed youth stated they are currently participating in sex offender groups; two youth indicated they were participating in T4C; one youth indicated they were participating in substance abuse groups; and one youth indicated they are enrolled in groups, but they refuse to participate in the groups when they go. The same seven youth indicated they had learned the following new skills or behaviors from the groups they have participated in: coping skills, maintenance and grooming skills, how to deal with triggers and anger, age of consent and the Florida laws, healthy relationships, healthy fantasies, long term effects of drugs, impact of crimes, and how to think differently and not to react to everything. An interview with the program director indicated each youth's commitment packet is reviewed by program staff and then the management team meets and discusses the youth's history. During this time the management team assigns the youth to a case manager and a therapist who the team feels will work best to meet the youth's needs while in the program. All youth committed to the program begin the sexual offender specific groups with their assigned mental health therapist immediately upon admission. Youth are then placed in additional intervention groups based on their risk-level to re-offend and their history/needs from the record review.

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 uses the Impact of Crime (IOC) and Thinking for a Change (T4C) curriculums to teach and reinforce the idea of restorative justice awareness to the youth in the program. A review of twelve staff training records verified three staff are trained to facilitate IOC and five are certified to facilitate T4C groups. A review of the program's schedule confirms the program has set times in the afternoon hours for the delivery of the restorative justice groups and they are delivered once a week for one hour. A review of seven youth case management records and group sign-in sheets confirmed all youth were currently participating in IOC and/or T4C groups. Since the last annual compliance review, the program has also had guest speakers at the program who were victims or families of victims impacted by crimes committed by youth in to speak with the youth. The guest speakers shared their personal experiences, thoughts and feelings with the youth to help them better understand the impact their crimes have on individuals. An interview with the designated mental health clinician authority (DMHCA) indicated the youth have participated in the following reparation activities: feeding the homeless, volunteering with Women Helping Others (a women's victim group), volunteered with The River church to help beautify a new playground for the children, and volunteered for Feeding Tampa Bay, where they assist in preparing over 10,000 meals for the less fortunate and they help at the Lighthouse Gospel Ministries with preparing community food baskets. An interview with the program director indicated the program uses the curriculum IOC as their main restorative justice curriculum. The program director indicated the IOC groups are conducted every Thursday from 11:30 a.m. to 12:30 p.m. The director confirmed the program has guest speakers who come to the program to provide the youth with a realization criminal acts are personal and can happen to anyone at any time. The guest speakers also help the youth gain an understanding of the victim's perspective and how crimes impacted them, whether physically, financially, emotionally or psychologically. The director indicated the premise of IOC also presents opportunities for restorative justice, whereas, the youth are provided opportunities to give back to the community

by helping to feed the homeless, doing neighborhood clean-ups, participating in aquaponics, and food drives in the community, which are considered community service projects.

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

The program's recreational therapist facilitates Young Men's Work on Saturday evenings from 6:00 p.m. to 7:00 p.m. Young Men's Work is created for young men ages fourteen to nineteen and consists of twenty-six sessions, which focuses on breaking the cycle of violence from generation to generation. The program is using the Youth Men's Work: stopping violence and building community facilitator guide written by Allan Creighton and Paul Kivel, published in 1998. A review of group sign-in sheets confirms each group was conducted with less than ten youth and was taught by a trained facilitator. A review of seven youth case management records revealed five of the youth are currently participating in the Young Men's Work group. An interview with the designated mental health clinician authority (DMHCA) revealed the program has youth participate in the Lighthouse Men's breakfast held at the Lighthouse Church, which gives the youth an opportunity to listen to various male speakers who give testimonies on how they have overcome difficult times and obstacles in their lives, and the youth are able to share fellowship with other young men and male elders. The program nursing staff provide the youth with gender-specific health education by educating the youth on testicular cancer and teaching prevention tools such as self-screening. An interview with the program director indicated the program provides the youth at the program with the targeted gender group called Young Men's Work and the group is facilitated by the recreational therapist on a weekly basis.

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

The program has a policy and procedures in place indicating the program will be responsible for immediately entering any necessary alerts in the Department's Juvenile Justice Information System (JJIS) when risk factors or special needs are identified during or after the classification process. Upon recommendations from appropriate staff JJIS alerts are downgraded or discontinued. The program maintains an internal alert white board in the program administration conference room, where shift briefing is held. The internal alert board contains a photograph of each youth, their Department identification number, age, therapist, case manager and colored blocks under the information designating each youth's specific alerts. The program's alert board has a legend indicating the alert and the color block which indicates the specific alert. Attached to the bottom right hand corner of the white board is a copy of the most recently updated medical alert log. The internal alert board is available to all staff and is used during shift briefing to tell staff about the youth's alerts. A review of seven youth alerts confirmed the program's

internal alert board matched what was documented in the youth's record and the JJIS. Nine specific alerts were reviewed for the seven youth. All nine alerts were noted in JJIS and were verified prior to being entered into the system. Four of the nine alerts were required to be documented in the program's logbook and all alerts were documented on the appropriate date and shift in the logbook. Review team members who were reviewing case management, safety and security, clinical services and medical services indicated all alerts related to the reviewed youth were accurately reflect in JJIS and on the program's alert board. An interview with the program director indicated the program maintains a confidential alert board, which is maintained in the conference room for staff to review during shift briefing. The alert logs and boards are also maintained in master control and in the dietary area. The clinical director, director of case management, and director of nursing are responsible for entering and closing out JJIS alerts. Alerts are also reviewed during the daily management meetings.

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 addressing documentation, development and maintenance of youth records. The policy indicates the program will ensure the creation, utilization, and protection of youth records with the utmost priority. The policy further indicates the program will maintain an official case record for each youth which is kept in three separate records (individualized medical record, individualized clinical record and individualized case management record) all of which will be kept in locked, secure cabinets, behind two locked closed doors, and marked confidential. A review of seven youth individualized case management records, seven medical records and seven clinical records contained a tab with the youth's name, Department identification number, date of birth, county of residence, and committing office. All seven case management records contained the following sections; legal information, demographic and chronological information, correspondence, case management and treatment team activities and a miscellaneous section. All twenty-one reviewed records were labelled as confidential and were maintained in lockable filing cabinets and closets when not being used by the appropriate staff. All filing cabinets and rooms where youth records were maintained were marked as confidential.

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

The program has a policy and procedures in place which indicates the program will solicit input from the youth through multiple avenues of communication which will allow youth to give input and feedback on a daily, weekly, and monthly basis. The program uses grievance forms, request for services forms, weekly dormitory meetings, monthly town hall meetings and the youth advisory board meetings to solicit input from the youth. The program had documentation of monthly town hall meetings which were conducted on each of the three dormitories along with the youth care workers, supervisors, and administrative staff. A review of the youth advisory board binder indicated the program has had monthly youth advisory board meetings for the six months prior to the review. A review of the youth advisory board meetings indicates each dormitories youth mayor and program administrative staff attend each meeting. Documentation from the advisory board meetings support the youth collaborate on creating leisure activity

calendars, holiday schedules, group activities, and discuss concerns about the program. An interview with one of the youth dormitory mayors confirmed each dormitory has a community meeting every week to discuss issues, concerns and activities occurring within the program and on their specific dormitory. During the tour of the program, grievance forms and request of service forms were observed located on each dormitory supervisor desk for the youth to access. The program director indicated during their interview the program uses a formal process where the youth can solicit input on a conference request form. The form is readily available to the youth on their dormitory and they can submit the forms at any time. The youth also have dormitory community meetings and youth advisory board meetings, at which time they can solicit input and ideas to better the residential community. The youth also complete surveys which assist the program with innovative ideas to better the program and residential community. Seven youth were interviewed and six indicated they can provide input about what happens at the program in their community meetings, groups, dormitory meetings, and through grievances. The seventh youth indicated the program has meetings between administration and the youth; however, they do not participate and do not participate in improving the program environment.

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

The program has a policy and procedures in place indicating the program will maintain a community advisory board which serves as a link between the program and the community. The policy further indicates the purpose and duties of the advisory board is to keep the program in touch with the local community and allow the local community to better understand the goals, objectives, and purpose of the program, as well as to be involved with special projects.
The program has a community advisory board. A review of the program's advisory board binder indicated the program held advisory board meetings on December 13, 2018, and March 28, 2019. The program maintains an agenda, minutes, and sign-in sheets for each meeting. The program's advisory board has members from faith-based organizations, the business community, a victim advocate, school board representative, law enforcement, a parent/guardian of a child previously involved in the juvenile justice system and a judiciary staff. 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. An interview with the program director indicated the community advisory board meetings are held on a quarterly basis. Meetings are scheduled on Thursday's and the start time is either 10:30 a.m. or 11:00 a.m. The program director, and community liaison solicit active involvement of interested community partners including, but not limited to representatives from law enforcement, the judiciary, the school board, the business community, faith community, victim, victim advocate, or other victim services community representative, and a parent/guardian whose child was previously involved in the juvenile justice system. The program director further indicated they are continuously making efforts through email correspondence and telephone correspondence to invite all members to the quarterly meetings. The program director indicated the advisory board provides constant feedback to the program and provides the program with ideas on activities the youth could participate in. The program youth participated in an event with a local organization called the Help Place, which was an idea brought up at the advisory board meeting. Other activities and ideas brought up by the advisory board was for the program to work closely with habitat for humanity, the strawberry festival, and other various organizations in the neighborhood, which the program has followed through with and are actively participating with.

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

The program conducts monthly all staff meetings, daily management meetings, and monthly supervisor meetings to ensure information about the program and youth is communicated with staff. The program also conducts weekly meetings with each dormitory to gather information from the youth regarding programming needs, as well as any other issues concerning the youth. The program director and assistant program director meets with the supervisory staff monthly to share information about the program, share information about the youth and to update the supervisors on company policy and procedures. A review of staff meeting agendas and minutes confirmed the above meetings are held daily and monthly. The program reviewed the comprehensive accountability report (CAR) with the staff during the March 2018 monthly general staff meetings. The program did not review the program's last annual compliance review with the staff because the review was conducted when the program was operated by a different provider. The program conducts surveys with parents/guardians and with the youth to seek comments or suggestions on program improvements, along with their satisfaction with the program. The survey results are discussed during management meetings and at the general staff meetings and the information is used to enhance the program's services. A review of hard copies of the surveys completed with parents/guardians and youth, as well as management meeting minutes confirmed the surveys are being completed and discussed during the management meetings. The program offers various incentive programs for staff to minimize staff turnover, as well as to increase staff morale. The program uses a reward system such as employee of the month/year and acknowledgment of outstanding job performances. The staff who are acknowledged for the above achievements receive gift cards to various local companies. Another incentive the provider uses to maintain staff is to provide the staff with paid time off upfront, by providing it upfront it encourages staff to relax, spend time with their families and enjoy leisure time. The program also provides staff with the opportunity to sell back some of their accrued paid time off to help supplement their income. The program also has a daily pay benefit for staff, which allows staff to access wages ahead of payday to help them pay bills and decrease stress. The program provides their staff with discount shopping at over five hundred vendors by providing them with a discount code. The provider also has contests throughout the year where employees could earn money. The latest contest was held in December 2018, where the employees could submit a video about why people should work for the provider and the staff could earn up to five hundred dollars for first place.

An interview with the program director indicated all direct care staff and shift managers meet for a shift briefing prior to the beginning of each shift. Program development and/or changes are discussed during the shift briefings. The director also indicated daily management meetings occur Monday through Friday and all components of the program are discussed and passed on to staff as necessary. The program also has shift supervisor meetings monthly and the program conducts all staff meetings once a month.

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

The program has a policy and procedures in place indicating staff and volunteers have a clear understanding of their position and an opportunity to receive feedback regarding job performance. The policy indicates volunteers will meet with the volunteer liaison for review of their position description. The policy further indicates all employees will receive a ninety-day and annual evaluation to assess competency in their position. The program maintains job descriptions for all different employee types. A review of the program's job descriptions revealed they all include a staff title, who the position supervises, typical work week, position summary, essential job functions, skills and abilities, education requirements, experience requirements, certification and licensure requirements, job physical demands, work environment and an area for the employee to sign the job description. All fourteen reviewed employee records contained a signed job description, which was signed by the employee upon hire or promotion. A review of fourteen employee personnel records revealed all were applicable for the completion of an evaluation and the evaluations were found in each employee's record. All evaluations critique each employee on quality of the staff's work, their productivity, job knowledge, reliability, attendance, education, initiative, adherence to policy, interpersonal relationships, judgement, competence, and group facilitation, if necessary. All reviewed evaluations were signed by the supervisor completing the evaluation and the employee. An interview with the program director indicated the program has not had any problems with staff turnover or staff morale since the last annual compliance review. The director indicated the program vacancies remain low and all key personnel have remained at the program throughout the year. The director further indicated employee incentives are continuously being given to staff to show the organizations appreciation and commitment to the staff who work every day with the troubled youth. Additionally, as a company, they use an instrument called the GERI indicator, which is a staff survey, which gauges a multitude of areas and provides insight as to how overall staff morale is with the program. The program director indicated all outcome data is reviewed regularly by management at the weekly management team meetings, by staff at the monthly all staff meetings, as well as other specific departmental meetings. The program also uses youth and staff surveys, weekly and monthly reports, and contractual program performance measures as a means of evaluating the program's outcome data. The director further indicated information regarding the CAR report and other reports published by the Department are shared with staff during the monthly general all staff meetings and daily management meetings. The program director indicated annual evaluations are completed for all staff which are employed at the program for the year. Each department head or supervisor are responsible for completing the evaluations for each of their subordinates. The director further indicated evaluations are reviewed and discussed with each employee individually. A copy of the evaluation is maintained in each employees' personnel record. All staff who facilitate a delinquency intervention group receive a rating about their facilitation skills on their evaluation.

Standard 2: Assessment and Performance Plan

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

The program has a written policy and procedures regarding initial contacts to parents/guardians which includes a telephone call within twenty-four hours of admission and written notification within forty-eight hours of admission. Seven youth case management records were reviewed, and all contained documentation in the chronological notes indicating the parent/guardian was contacted by telephone indicating the parent/guardian was informed of the youth's arrival and program information. All records indicate the youth spoke to their parent/guardian at intake. All records indicate a written letter was mailed to the parent/guardian on the day of intake informing the parent/guardian of the youth's admission and included a parent handbook, directions to the program, a performance plan questionnaire, gang information, youth visitation log, program contacts, and notification of formal treatment team dates. Three of the reviewed records were youth in the care of the Department of Children and Families (DCF) and a letter was mailed to the DCF case manager on the day of intake with the above information included. All records reviewed contained a copy of the letter sent to the committing judge mailed on the day of admission. All records reviewed contained a letter to the juvenile probation officer (JPO) informing them of the youth's admission to the program sent on the same day as the youth's admission. Letters to the JPO included the youth's anticipated length of stay, treatment team schedule, and all pertinent contact information.

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 written policy and procedures regarding youth orientation. Seven youth case management records were reviewed, and all contained documentation the youth participated in an orientation on the day of admission. All records contained an orientation checklist which contained the following information: room/living assignment, daily schedule, treatment team overview, introduction of key staff, abuse and grievance procedures, services provided, the behavior management system including consequences, visitation, mail and phone use policies, access to medical and mental health services, search procedures, contraband and the use of Class B tools. All orientation checklists reviewed were initialed and signed by the youth and case manager. All records contained a copy of the youth handbook, including a signature page signed by the youth and staff 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. All youth admissions were documented in the facility logbook. An interview with seven youth indicated their orientation started on the day of their admission. All interviewed youth indicated their orientation included the program rules, procedures, and program schedule. One of the youth further indicated they signed a lot of papers, was advised about the program's length of stay and told therapy would occur daily. There was one youth admitted to the program on the first day of the review and the review team did not have an opportunity to watch the program's admission process.

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 written policy and procedures stating the program will obtain written consent of youth eighteen years or older giving authorization for use or disclosure relating to the youth's physical or mental health screening, assessment, or treatment. Seven youth case management records were reviewed for the written consent of youth eighteen years or older. Of the seven records reviewed, only one record was applicable as the remaining six youth were under the age of eighteen. The program provided the reviewer with two additional records of youth eighteen years of age or over to ensure compliance. Each of the applicable records contained signed documentation allowing the release of information regarding physical or mental health screening, assessment, and/or treatment with their parent/guardian. The forms also identified the purpose of the use of disclosure, expiration date, a right to revoke the privilege, and the person authorized to receive the protected information. All forms were signed on the day of admission as the youth were all eighteen at the time of admission. Additionally, the program provided documentation of a tracking system for youth expected to turn eighteen while in the program; therefore, ensuring the release of information will be signed on each youth's eighteenth birthday.

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

The program has written policy and procedures outlining the classification process for newly admitted youth. An admission classification meeting is held to assist staff in identifying the physical characteristics of the youth, special needs, maturity, age, history of violence, gang affiliation, past criminal behavior, and/or sexual aggression/vulnerability to victimization. Safety and security risks are identified to assist the staff in guiding the decision-making process determining youth's living unit assignments, room assignment, and the staff assigned to the youth. Seven youth case management records were reviewed, and each contained a copy of the admission classification form completed on the day of admission. The forms addressed all above information, as well as suicide risk, medical risk, escape risk, or any other security risk which could impact the youth and/or their living environment. There was documentation in all reviewed records the program also reviewed juvenile justice information system alerts, the youth's electronic commitment packet documents, and contacted the youth's assigned juvenile probation officer to gather further information for classification. All admission classification forms were signed by the youth, treatment team director, case manager, therapist, nurse, living unit representative, and indicated if the parent/guardian participated by telephone. The program has

a system in place for reassessing the youth for use of class B tools monthly, as well as a system for assessing the youth prior to off-campus activities. A review of the seven records revealed all youth received a risk re-assessment prior to an increase in privileges and prior to being able to use class B tools. None of the seven reviewed youth were re-assessed for participation in off-site activities. An interview with the program 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.

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 written policy and procedures in place to outline the process of notifying the appropriate parties of youth entering the program with suspected gang affiliation, or documented gang membership, as well as for youth who are observed engaging in gang activities while in the program. Seven youth case management records were reviewed; however, only one youth was applicable for gang affiliation or membership. The program was able to provide two additional youth records for review of gang identification and notification. There was documentation in all three applicable records the youth admitted gang involvement during admission to the program or after their admission. There was documentation in each record gang notification letters were mailed to the local sheriff's office, the youth's home county sheriff's office, local school board representative, and the youth's assigned juvenile probation officer.

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 to implement gang prevention and intervention services. 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. A review of seven youth case management records indicated one youth identified themselves a gang member upon admission to the program. The case management team was able to provide the reviewer with two additional records for review of youth who were classified as gang members or affiliates either at admission or after admission. One of the records was a youth who was recently released from the program; however, the youth had completed the ARISE curriculum worksheets and completed the curriculum prior to their release. The second record reflected the youth was identified as a gang member at the beginning of March 2019 based on gang related activities observed since being in the program. The youth and treatment team members placed a goal for gang prevention and intervention on the youth's performance plan during the youth's treatment team and the youth's record reflects the youth has participated in one ARISE group session. The youth has also been enrolled in the IOC groups. The third youth was identified as a gang member at admission, which was November 2018, and goals were placed on the youth's initial performance plan for gang prevention. According to the director of case management the youth's attitude and behaviors since arrival have prevented the program from starting the youth on the ARISE curriculum. The program was working on adjusting the youth's behaviors prior to starting the

curriculum. There was documentation to support the youth participated in a gang intervention talk with a guest speaker; however, the youth did not start the ARISE curriculum until the week prior to the annual compliance review. The youth's record further reflects the youth was participating in the IOC curriculum as a preventive measure.

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

The program has a policy and procedures in place to ensure the Residential Positive Achievement Change Tool Assessment (R-PACT) and reassessments are completed within the required timeframes. Seven youth case management records were reviewed, and all records contained an initial R-PACT completed within thirty days of the youth's admission. All seven records were applicable for R-PACT reassessments and all reassessments were completed ninety days after the completion of the initial R-PACT. All completed R-PACTs were in the youth's official 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 YNAS.	

The program has a policy and procedures in place to ensure the Youth Needs Assessment Summary (YNAS) is completed within the required timeframes. Seven youth case management records were reviewed, and all the records contained a completed YNAS within thirty days of the youth's admission. Each record contained documentation demonstrating the participation of the treatment team, youth, parent/guardian, and juvenile probation officer's involvement in the completion of the YNAS and the prioritization of the youth's current needs.

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 the required timeframes. The program holds a needs assessment meeting with all parties prior to the development of the performance plan to discuss the youth's history and the youth's needs identified by all the assessments. At the meeting all parties discuss the youth's needs and prioritizes the needs. Seven youth case management records were reviewed with all records containing documentation of the performance plan being developed within thirty days of the youth's admission. All performance plans were developed following the youth's initial needs assessment. The treatment team was present during the development of the performance plan as indicated by documentation of the youth's needs assessment meeting; included in the needs assessment meeting were the treatment leader, youth, administrative representative, living unit representative, treatment staff, educational staff (or written input was obtained), and the youth's Department of Children and Families (DCF) case manager, if applicable. All seven records contained an initial performance plans signed by all required treatment team members. There was documentation in each record the performance plan was sent to the parent/guardian with a request to sign the plan and return it to the program. 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 on the needs of the youth. Delinquency interventions, court-ordered sanctions, transition activities, youth responsibility, program staff responsibility, and targets dates were documented on all reviewed performance plans. There was documentation in all seven records the performance plans were submitted to the committing court, parent/guardian, juvenile probation officer, and DCF counselor, if applicable. Seven youth were interviewed and six of the youth indicated they received a copy of their performance plan, with one youth indicating they had not received a copy of their performance plan. Six of the seven interviewed youth indicated they all participated in the development of their performance plan and they were able to articulate what goals they were currently working on. The seventh youth indicated their goals were given to them by their case manager and they are not working on the goals because they do not agree with them. Some of the goals the youth indicated they were working on were anger, how to react appropriately, vocational goals, substance abuse, communication with family, impulse control, dealing with depression, and relationships.

2.10 Performance Plan Revisions	Limited 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 policy and procedures in place to ensure performance plan reviews are completed monthly. Seven reviewed youth case management records include documentation performance plan reviews occurred every thirty days during the youth's formal treatment team meeting. Four of the seven reviewed records had changes to the youth's criminogenic needs identified by the Residential Positive Achievement Change Tool (R-PACT) ninety-day reassessment; however, the case management staff did not address the new needs in the performance plan reviews. The case management staff did not add new goals to the performance plans, nor was there documentation to support the reason why the newly identified needs were not being addressed in the revised 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 are completed ninety days after the completion of the initial performance plan. Seven youth case management records were reviewed for the completion of performance summaries and only six of those records were applicable for performance summaries. None of the applicable records contained documentation a performance summary was completed prior to the youth's release, discharge or transfer from the program. All performance summaries included the youth's status on performance plan goals, youth's treatment progress, academic status, youth's behavior, level of motivation/readiness for change, interaction with peers, interaction with staff, overall behavior adjustment to the program, and significant positive and negative events. All performance summaries were signed by the treatment team leader, staff member preparing the performance summary, program director, and youth. There was documentation in all applicable records the youth could read and add comments to each performance summary prior to signing them. Seven interviewed youth indicated they all received a copy of their performance summaries. All original performance summaries were maintained in the youth's official case management record. There was documentation in all applicable records the performance summaries were transmitted within ten working days after completion to the committing court, juvenile probation officer, youth, parent/guardian, and the Department of Children and Families, if applicable.

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 Positive Achievement Change Tool (R-PACT). All three closed records were youth who were considered sexually violent predators and required additional discharge documentation or notifications. All additional discharge information was completed as required for each youth. There was documentation in each youth's record to confirm the program mailed out a victim notification letter prior to the youth's release from the program. An interview with seven youth indicated six of the youth are attending groups daily; however, the seventh youth indicated they do not attend groups. Due to the seventh's youth response the director of case management was interviewed and indicated the youth frequently refuses to attend groups.

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 policy and procedures in place to ensure parent/guardians, and the Department of Children and Families (DCF), if applicable are involved in the case management process for each youth. An interview with the program director indicated each youth's parent/guardian are contacted upon admission and parent/guardians are invited to participate in all treatment team meetings either by telephone or in person. The director also indicated parent/guardians receive written communication about their child's progress on a regular basis and are invited to participate in clinical family sessions in person or by telephone. The program also conducts quarterly family days, which allows the youth's parent/guardians to come to the program and be involved in the youth's residential community. The program also has visitation hours weekly and allow approved family members to visit with the youth and talk with the case management, as well as clinical staff to help the youth progress through the program. The reviewer was able to observe two youth treatment team meetings and each of the youth's parent/guardians were contacted and participated in the meetings.

Seven youth case management records were reviewed and there was documentation in each record the youth's parent/guardian or DCF case manager were involved in the assessment process, development of the youth's performance plan, progress reviews, and treatment team meetings. All records contain 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 five of the youth indicated their parent/guardians are involved in their case management process by telephone. Of the two remaining youth one indicated they were in the care of DCF and the other youth indicated they did not want their parent/guardian involved in their case.

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. Observations of two formal treatment team meetings indicated the presence of the following treatment team members: treatment team leader (case manager), youth, living unit

representative, therapist, administrative representative, parent/guardian, juvenile probation officer (JPO), transition specialist, recreational therapist, and education staff. The JPO and the parent/guardian participated in the meetings 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. A review of seven youth case management records revealed each plan included a goal which addresses the youth's compliance and achievement of their specific academic plans, and clinical plans. Three of the reviewed records were youth who were under the supervision of the Department of Children and Families (DCF). None of the youth's plans contained a specific goal indicating the youth would work on completing their DCF plans; however, there was documentation in each youth's record the case manager, the youth and DCF worker were all working together for the youth to complete their residential performance plans and were maintaining contact with their DCF case worker. During the review, each of the three youth's performance plans were updated to reflect a goal specific to the youth working with their DCF case worker and/or on their DCF case plan. 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 R-PACT reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions. If the youth has a treatment plan, review their treatment progress. *A residential commitment program shall ensure the intervention and treatment team reviews each youth's performance, including R-PACT reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions. If the youth has a treatment plan, review their treatment progress.*	

The program has a policy and procedures in place to ensure the youth participates in formal treatment team meetings every thirty days. The purpose of the meetings is to review the youth's performance, Residential Positive Achievement Change Tool (R-PACT) Reassessment results, progress on performance plan goals, and positive and/or negative behaviors, including behavior resulting in physical intervention. Seven youth case management records were reviewed and there was documentation of invitations to the youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties to participate in each of the youth's formal treatment team meetings. There was documentation in all reviewed records the program held formal treatment team meetings on each youth every thirty days, and all required individuals attended each of the formal treatment team meetings. The formal treatment team meeting forms documented the youth's name, date of the review, individualize in attendance, comments made by the treatment team attendees, a brief synopsis of the youth's progress, any performance plan

revisions being made, the youth's progress on performance plan goals, the youth's positive and negative behaviors, behaviors resulting in physical intervention, treatment progress, the R-PACT results, and each treatment team form had an area where the youth could provide a statement and demonstrate the skills they have learned in the program. In all seven reviewed records, there was documentation of bi-weekly informal performance reviews which included the same information as the formal treatment team meeting; however, the meeting was held with only the youth and their case manager. Observations of two formal treatment team meetings indicated the presence of the following treatment team members: treatment team leader (case manager), youth, living unit representative, therapist, administrative representative, parent/guardian, juvenile probation officer (JPO), transitional specialist, recreational therapist, and education staff. The JPO and the parent/guardian participated in the meetings by telephone. During the observed treatment team meetings, the youth was given an opportunity to speak and demonstrate skills learned in the program. An interview with seven youth indicated they are all provided an opportunity during their treatment team meetings to demonstrate skills they have learned in the program. One youth indicated during their meeting they talk about what they have been doing in the program for the past few weeks. The second youth indicated the team asks me what I am doing on the dormitory, in class and how I have been handling myself. The youth also indicated they are the mayor of their dormitory and during their meetings the living unit representative expresses to the team how the youth is behaving on the dormitory. The third youth indicated they choose not to participate in their treatment team meetings because the staff hound them on what they need to be doing in therapy, as well as at the program and the youth does not agree with it. The fourth youth indicated they can demonstrate things they have learned. The fifth youth indicated the team has them define things, such as how they are going to apply the things they have learned in the dormitory and out in the community when they leave. The sixth youth indicated they let the team know how they are doing in the program and the team discusses whatever the youth wants to talk about. The seventh youth did not make a comment about their participation in their treatment team meetings.

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

The program's career education programming is provided by the Hillsborough County School Board (HCSB) and has been identified as a Type 2 career education program. The educational programming provides an orientation to each youth with career choices based on personal abilities, aptitudes, and interests which are appropriate for youth of all ages and abilities. The program teaches personal accountability skills and behaviors, such as communication, interpersonal skills, and decision-making. The lead teacher was interviewed, and they indicated the program offers the following career education services: Safe Staff, Serve Safe – Professional Manager, and Ready to Work. The lead teacher further indicated each of the youth's career education is maintained in their individualized student folder, case management records and with the career and technical educational staff. The lead teacher indicated the school staff provide bi-weekly emails on the youth's progress in education to each youth's case manager, and they also provide written input on the youth's academics for each of the youth's formal treatment team meetings. An interview with the program director indicated the program has a culinary arts program, which allows the youth to earn certification which can assist them with gaining employment in the culinary field. The director confirmed the youth can earn the following certification: Safe Staff, Serve Safe – Professional Manager, and Ready to Work.

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 contracts with the Hillsborough County School Board (HCSB) to provide educational services to the youth at the program. The HCSB provides educational services to the youth for 250 days a year, with ten of those days being used for teacher training and meetings. An interview with the lead teacher indicated educational services start at the program at 7:45 a.m. and go until 11:10 a.m., when the youth break for lunch. Education then resumes at 12:25 p.m. and goes till 2:05 p.m. for a total of six different fifty-minute classes for a total of 300 minutes of educational services each day. The youth are provided face-to-face instruction twenty-five hours a week. A review of the program's daily schedule and logbooks for the six months prior to the review indicated educational instruction is rarely interfered with. The lead teacher provided the reviewer with a testing schedule and the teacher indicated testing is the only time the education schedule is deviated from. Seven youth were interviewed about interruptions during educational instruction and four youth indicated education is not disrupted. Three youth indicated education is interrupted by youth talking loudly, by youth behavior, and one youth indicated they get kicked out of class frequently for the way they are sitting.

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

The program has a cooperative agreement with the Hillsborough County School Board (HCSB) to provide educational services to the youth at the program. Three closed records were reviewed for educational transition planning. All three youth had an individualized education transition plans developed based on the youth's post release educational goals and the plan was started when the youth was admitted to the program. All educational transition plans included information regarding the youth, parent or guardian, educational representatives, and juvenile probation officer (JPO). The program has a certified school counselor from the local school district who is responsible for providing guidance services to the youth at the program. The program also has a registrar from the local school district who has access to the district's management information system, to maintain appropriate school records on the youth. All three reviewed educational transition plans addressed services and interventions based on the youth's assessed educational needs and post-release education plans, as well as the recommended educational placement for post release. All reviewed educational transitional plans addressed specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services. All three reviewed records reflected each youth had employability as a goal on their performance plan during the transitional phase of the program. All three youth records contained a sample of completed job applications, a completed resume, a valid Florida identification card, and a calendar with an appointment at the youth's local career source center for when they return to their home community. All three records contained all appropriate documents essential for the youth to obtain employment upon their release. There was also evidence in each youth's record the youth's case manager, and parent or guardian(s) were made aware of the youth's educational transition plan, documents for employment and post-release discharge plans.

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. A review of three youth closed case management records found all youth had transition planning including transition conferences, which were held at least sixty days prior to the youth's targeted release date. Documentation confirmed the youth, treatment team leader, facility administrator or designee, parent/guardian, and any other pertinent treatment team members were invited and present during each youth's transitional conferences. In addition, transitional planning was developed with the youth, education, program staff, and aftercare staff. All three youth records contained evidence the youth and case managers participated in a Community Re-entry Team (CRT) meeting held prior to the youth's release.

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. A review of three youth closed case management records contained an exit portfolio. Each portfolio contained a copy of the youth's Florida identification card, social security card, birth certificate, transition plan, and had a calendar containing follow-up appointments. The portfolio also included completed sample job applications, resumes, vocational certificates, educational records, and education transcripts. The program uses a form in which the youth and parent/guardian signs stating they received their exit portfolio upon release.

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

Three youth closed case management records were reviewed for the completion of an exit conference. All three records contained documentation an exit conference was conducted after the juvenile probation officer (JPO) was notified of each youth's release. All the records reflected the exit conference was conducted at least fourteen days prior to the youth's release. 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

individuals participated in the exit conferences for each youth: treatment team leader, parent/guardian, education representative, JPO, and youth. Exit conferences were held separately from transition meetings for each youth. A review of the Department's Juvenile Justice Information System (JJIS) 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 licensed mental health clinician (LMHC) who serves as the designated mental health clinician authority (DMHCA). They are employed full-time by the program and are on-site at least forty hours a week. They are also available twenty-four hours a day, seven days a week in the event of a mental health or substance abuse emergency. A review of their license found it to be current and active. An interview with the DMHCA reflected they are responsible for ensuring the timely and accurate completion of the required assessments, evaluations, and treatment plans. In addition, they must ensure the treatment programming at the program complies with all requirements outlined in the program's contract. The program has a LMHC, who serves as the assistant clinical director, who serves as the backup in the absence of the DMHCA. A review of their license found it is also current and active. The program maintains a position description for the DMHCA and it was available for review during the annual compliance review. An interview with the DMHCA indicated they are responsible to ensure the timely and accurate completion of comprehensive mental health and substance abuse evaluations, facilitate mental health and substance abuse treatment groups, review and sign-off on comprehensive assessments, Assessments of Suicide Risk, initial treatment plans, individualized treatment plans and treatment plan reviews, and to complete the clinical department management report monthly. In addition, the DMHCA ensures the program clinical treatment programming complies with the required outline within the specialty services guidelines. The DMHCA also indicated they are responsible for emergency coverage twenty-four hours a day, seven days a week in the event of a mental health or substance abuse emergency. The DMHCA further indicated they are on-site five days a week, Monday through Friday from 8:30 a.m. to 5:30 p.m.

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 seven licensed clinicians to provide treatment services to program youth. The designated mental health clinician authority (DMHCA), who is a licensed mental health counselor (LMHC), provides oversight for all treatment and case management services offered within the program. The program has an assistant clinical director, who is also a LMHC, who serves as the backup for the DMHCA in their absence. Additionally, the program has five licensed therapists who are each assigned a caseload of ten youth, for which they provide

assessments, evaluations, and treatment planning services. Three of these therapists are LMHCs and two are licensed clinical social workers (LCSW). Additionally, all have been certified to provide Juvenile Sex Offender (JSO) treatment services and the certification was approved through the Department's Office of Health Services. The licenses for all clinicians are current and active, with no restrictions. All clinician's licenses expire on March 21, 2021.

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

The program has a written policy and procedures which reflects the program will employ six licensed clinicians. Reviewed documentation validates the program has followed the policy since the provider took over the contract on April 2, 2018.

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

The program has a written policy and procedures which explain their comprehensive screening process conducted on each youth at admission. A review of documentation confirmed they follow the procedures outlined in the policy. Prior to the youth's arrival in the program, case management staff conduct a review of the youth's commitment packet information which is in the Department's Juvenile Justice Information System (JJIS). The intake case manager then completes a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) on each youth as part of their admission process. The reviewed documentation in all seven records confirmed the assessment was completed on the day of admission by a case manager and was entered into JJIS. Each reviewed MAYSI-2 was conducted by a trained staff. Reviewed documentation also confirmed all available information was also reviewed to ensure they get a clear picture of the youth's history. When the MAYSI-2 indicated a need for further assessment, each youth was referred for further evaluation by a licensed clinician using the program's mental health services referral. Three of the seven youth had a "hit" on the MAYSI-2 in the category for suicide ideation. Each of the youth had a referral completed, and they were seen by a licensed clinician the same day for the completion of an Assessment of Suicide Risk (ASR). The other four youth had an ASR completed the day of admission as part of the program's assessment process; however, they did not have any hits for suicide on the MAYSI-2. Additionally, there was documentation to reflect a licensed clinician reviews each youth's Pre-Disposition Report (PDR), their most recent Positive Achievement Change Tool (PACT), and any available psychiatric/psychological reports during the admission process. Due to the specialized nature of youth sent to the program, the licensed clinician also completed an Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) assessment tool and a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening to assist with the program's classification process and to help develop initial treatment plan goals. Interviews with the executive director and designated mental health clinician authority (DMHCA) confirmed the program's admission process outlined above.

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

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

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

Each youth is assigned to a treatment team on their day of admission. A review of seven youth clinical records found a description of the treatment team which was reviewed and signed on the day of admission by the youth and a licensed clinician. A review of treatment plans and reviews confirmed the team consists of all required members. Observations of treatment team meetings confirmed all required staff are present at the meetings and discuss the youth's treatment needs and progress. The mental health and substance abuse daily service progress notes for seven youth were reviewed. The mental health treatment notes were documented on a form which contained all the information found on the Department's Counseling/Therapy Progress Notes form. The review confirmed six of the youth received services as set forth in their individualized treatment plan, without any exceptions. The seventh youth did not participate in group therapy as prescribed; however, the youth has a history of being aggressive towards women. Based on the concern, the program initially included a note in the youth's initial safety plan excusing the youth from treatment groups which were facilitated by female therapists until the youth could be reassessed. Due to behaviors which continued, the program updated the youth's safety plan to recommend the youth be accompanied to groups by male staff. Additionally, the plan indicates the youth should not be alone with female staff. An interview with the designated mental health clinician authority (DMHCA) indicated the primary therapist is meeting with the youth following non-attendance of groups to have supportive sessions relating to the missed group sessions.

The program provided documentation for each of the supportive sessions held with the youth's primary therapist after each missed group. Six of the seven records contained a signed youth consent for substance abuse treatment form, and a youth consent for release of substance abuse treatment records form. The seventh youth refused to sign all forms during their intake. The youth was assessed and did not require substance abuse treatment. Four of the seven youth also had a properly executed Authority for Evaluation and Treatment (AET) form in their mental health and substance abuse record. The fifth youth who was over the age of eighteen and had a release of information document in their record. The sixth youth was in the custody of the Department of Children and Families (DCF) and was found to have a court order authorizing their treatment. The seventh youth was also in the custody of DCF and had a signed Department form HS 057(limited consent for evaluation and treatment). A review of all seven youth mental health and substance abuse daily service progress notes, as well as group sign-in sheets validated mental health groups had no more than ten youth in a group and substance abuse groups had no more than fifteen youth in a group. During the annual compliance review, observations of a mental health treatment group also found there were no more than ten youth in the group.

An interview with the DMHCA confirmed the program provides mental health treatment groups, substance abuse treatment and prevention groups, family counseling, individual counseling, and psychosocial skills training. The DMHCA indicated their treatment groups take place on the following days: Skillstreaming on Monday; Pathways (sex offender treatment curriculum) on Tuesday, Wednesday, and Thursday; Healthy Sexuality (youth not in substance abuse treatment) and Living in Balance (substance abuse treatment group) on Friday; and Life Skills Training is provided on Saturday and Sunday for all youth. Six of the seven interviewed youth indicated they attend group treatment. The seventh youth indicated they do not attend groups. Further interviews with staff reflected the youth refuses to attend groups on a regular basis. Seven interviewed staff indicated they do not facilitate mental health or substance abuse groups. They did indicate trained staff may facilitate Impact of Crime (IOC) and Thinking for a Change (T4C) groups.

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

The program has a written policy and procedures to define how they will complete their treatment and discharge planning. Seven youth clinical records were reviewed, and all records contained an initial treatment plan completed on the date of admission and included the frequency of medication management for youth admitted to the program with psychotropic medication. The initial combined mental health and substance abuse treatment plan was documented on a form containing all required elements of the MHSA 015 form (Initial Mental Health/Substance Abuse Treatment Plan). All initial treatment plans contained a signature of the program's licensed mental health clinical staff. The initial treatment plans were also signed by

the youth and all treatment team members who participated in the development of the plan, to include the parent/guardian, when applicable. All initial treatment plans included the youth's psychiatric needs, including medication and frequency of monitoring by the psychiatrist. The initial treatment note was contained on the program's initial treatment plan form. In all seven records reviewed, an individualized treatment plan was developed within thirty days of admission. The individualized treatment plan was signed by a licensed mental health clinical staff person and was developed on a form which contained all the required elements of form MHSA 016 (Individualized Mental Health/Substance Abuse Treatment Plan). All reviewed records contained individualized treatment plans signed by all treatment team members who participated in the development of the plan. Five of the individualized treatment plans indicated the youth needed psychiatric services; in all five applicable records, the youth had psychiatric services included on their plan. Psychiatric services include psychotropic medications and frequency of monitoring by the psychiatrist. All seven records reflected the individual treatment plan reviews were completed on a form containing all required elements of the MHSA 017 (Individualized Mental Health/Substance Abuse Treatment Plan Review) form. All seven records contained documentation of treatment team reviews occurring a minimum of every thirty days. Three closed records were reviewed for discharge planning. Each of the records contained a discharge plan completed on the MHSA 011 form (Mental Health and Substance Abuse Treatment Discharge Summary). In the three records reviewed, none of the youth were applicable for notifications of suicide risk upon the youth's discharge. Documentation reflected the mental health and substance abuse (MH/SA) treatment discharge summary considered the services needed for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by the youth during treatment. All records contained documentation reflecting the discharge plan was discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. Documentation in all records reflected a copy of the MH/SA treatment discharge summary was provided to the JPO, youth, and parent/guardian.

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 conducts mental health and substance abuse evaluations, to include sex offender evaluations. The program provides sex offender treatment planning and juvenile sex offender therapy and uses the Pathways curriculum as their main sex offender group treatment. Individual, group, and family therapy (including mental and substance abuse counseling) and crisis interventions are also provided to the youth at the program. Life Skills Training and Skillstreaming curriculums are also provided to the youth weekly. The program has a contract with a psychiatrist who is on-site weekly for consultation and medical management, and to participate in treatment planning for youth receiving psychotropic medication. The designated mental health clinician authority (DMHCA) is on-site five days a week for at least forty hours. There are also six licensed mental health clinical staff on-site seven days a week, to include an assistant DMHCA who provides staffing coverage and completes initial treatment plans during the admission process. All clinical staff are certified in juvenile sex offender therapy. A review of the licensed therapist caseloads revealed they do not exceed ten youth, per contractual requirements. An interview with the program director indicated the program provides sex offender specific treatment using the Pathways curriculum. The director indicated the curriculum is an evidence-based treatment intervention and focuses on strength-based methods to help clients develop healthy and

productive lifestyles away from sexual acting out behaviors. The director further indicated pathways uses a restorative justice theme emphasizing concern for restitution, development of victim empathy and personal responsibility. The treatment focuses on understanding the offense cycle, as well as understanding the adolescent's way 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.	

The program has a policy and procedures in place indicating youth with psychiatric needs will receive psychiatric evaluations, psychiatric consultations, medication management, and medical supportive counseling. The program contracts with a licensed psychiatrist who is a physician licensed under Chapter 458 or 459, F.S., and is board certified in psychiatry and has completed training in child and adolescent psychiatry. The psychiatrists license is clear and active in the state of Florida and expires on January 31, 2021. The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. There is also a psychiatric advanced registered nurse practitioner (ARNP) available as a back-up to the psychiatrist. The collaborative practice protocol and certification for the ARNP is on file with the Department of Health, as well as located on-site. The ARNPs license is clear and active in the state of Florida and expires on July 31, 2020. A review of the sign in/out logs confirmed the psychiatrist or back up ARNP was present every week for the past six months, which exceeds the contract requirement of bi-weekly contact. The documentation further supported the ARNP covered for the psychiatrist on four occasions.

The program's policy indicates all youth are referred for an initial psychiatric interview within fourteen days of admission, regardless of their psychiatric history. All seven reviewed records contained an initial psychiatric interview which contained all required elements to include history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), diagnosis, treatment recommendations, prescribed medication (if applicable), explanation of the need for psychotropic medication, and frequency of medication management. All initial psychiatric interviews were documented on the Department's Clinical Psychotropic Progress Note (CPPN) form. Five of the seven records reflected the youth entering the program with psychotropic medication and each record had page three of the CPPNs completed. All five youth were continued on the psychotropic medication during the initial psychiatric interview. One of the original seven reviewed records reflected the youth was prescribed psychotropic medication after admission. Two additional records were provided by the program for youth prescribed medications after admission. All three of the psychiatric evaluation were completed within thirty days of the referral and were completed using all three pages of the CPPN. All eight reviewed records where the youth was prescribed psychotropic medications, contained documentation each youth received monthly medication management.

An interview of the psychiatrist reflected the psychiatrist is on-site weekly and their role includes initial evaluations, treatment plan reviews, psychotropic medication management, and side effects reviews, and contacting the parent/guardians for consent of psychotropic medications.

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

The program has a written suicide prevention plan detailing the program's suicide prevention procedures. The plan outlines how the program will safely assess and protect youth with elevated risk of suicide in the least restrictive means possible. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, level of supervision, referrals, communication, notification, documentation, immediate staff response, and a review process. The plan was reviewed and signed by both the designated mental health clinician authority (DMHCA) and the program director on April 2, 2019. An interview with the program director indicates the staff received six hours of training in suicide prevention each year, which includes mock suicide drills.

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

The program has a written policy and procedures in place outlining the methods used for supervising, observing, monitoring, and housing for youth identified through screenings, review of available information, or staff observations as having suicide risk factors. A review of seven youth mental health and substance abuse records found each youth was screened with an Assessment of Suicide Risk (ASR) during their admission to the program. One of the seven reviewed youth had a "hit" for suicide ideation on their MAYSI-2. The youth was immediately placed on suicide precautions, and a referral was done to mental health. It is the program's practice to conduct an ASR on each youth during the admission process, regardless of whether or not any suicide risk factors were identified. Each of the six youth without risk factors was evaluated during admission, confirming the program's practice. Each of the six youth had an ASR administered by a licensed clinician on the day of admission, and each were maintained on standard supervision. The seventh youth also had an ASR done during their admission; however, they were continued on constant supervision. A review of the ASR reflected notification was made to the youth's parent/guardian and their assigned juvenile probation officer (JPO). The youth was then seen for a follow-up ASR the following day. The decision was then made to step the youth down to close supervision by a licensed clinician. The documentation also reflected a conference with a licensed clinician and the program director/designee prior to reducing the level of supervision. Each reviewed ASR and FASR were done by a licensed mental health professional. During the youth's heightened placement, their supervision was documented using suicide precaution observation logs and close supervision logs, when applicable. Documentation reflecting the placement status of the youth was found in

the master control logbook, and in the Department's Juvenile Justice Information System (JJIS) alert system.

Two youth in the sample were placed on suicide precautions during their stay at the program. One youth had one instance of placement on suicide precautions, and the other had two instances. Each of the two youth were seen for an ASR within twenty-four hours of the youth being identified at risk by a licensed clinician. All instances resulted in the youth being placed on constant supervision until they could be evaluated, and the supervision was documented using suicide precaution observation logs. There were no lapses in supervision seen on the reviewed logs. All instances resulted in the youth being stepped down to close supervision when deemed appropriate by a licensed clinician using the FASR form. All step downs from close supervision were done following the completion of a mental status examination, which follows the programs' policy and procedures. The program had no youth placed in secure observation during the review period.

Seven staff were interviewed regarding their responsibilities if a youth expressed suicidal ideations to them. All staff indicated they would notify mental health, place the youth on sight and sound supervision, and document the youth's behaviors. Six of the seven staff indicated they would search the youth and their room for sharp objects. All seven interviewed staff indicated the program maintains a suicide response kit on each dormitory and in master control. During the program tour, the review team observed suicide response kits in master control and locked in the supervisors' closet on each dormitory.

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

The review of seven youth clinical records found two of the youth had been placed on suicide precautions which required the completion of suicide precaution observation logs. One youth had one instance of suicide observations, and the other youth had two instances. There were eight logs available for review for the two youth's suicide observations. All logs were maintained for the duration the youth was on suicide precautions, and the staff documented the youth's behavior in real time at intervals which did not exceed thirty minutes. Each log reflected warning signs being documented after notification being made to the designated mental health clinician authority and the program director/designee. Clear instructions were provided for staff regarding the reasons for placement, and how the youth should be supervised. Each of the reviewed suicide precaution observation logs also had all required reviews by supervisory staff and licensed clinicians. Brief interviews were conducted with three youth who were placed on suicide precautions and they all stated staff were with them always and they were never left alone while on precautions.

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

The program has a policy in place which addresses suicide prevention training. A review of seven staff pre-service and seven in-service training records found each received six hours of

instructor led suicide prevention training. The program's mock suicide drills were reviewed for the past year. The review revealed the program conducts a mock drill quarterly on each shift on the same day the monthly all-staff meeting is held. Each of the drills included the time of the drill, the designated shift, name of who conducted the drill, the nature of the incident, persons involved/function of each, type of medical of care given, type of mental health/crisis intervention provided, the outcome of the incident, the time of response, and any follow-up or corrective action needed. In addition, there was documentation the management team provided a review/critique and the date of when the information was shared with all staff. The review also found sign-in sheets from the days the drill was conducted; however, concerns were noted with the sign-in sheets. Drill documentation revealed there were staff who signed in as participating in the drill when they had only reviewed the drill verbally at the all staff meeting. There was no separate sign-in sheet indicating which staff had participated in the drill and performed life saving measures, and which staff had only reviewed the drill at the all staff meeting. The annual compliance review team was able to verify the program had thirty-four staff at the program for the entire year who should have participated in two semi-annual mock drills. Documentation revealed only nine the staff participated in two semi-annual drills, nine staff participated in one semi-annual drill, and sixteen staff who did not participate in a mock suicide drill the entire year. There were an additional eleven staff at the program for three full quarters; four of those staff participated in one drill and seven did not participate in any drill.

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

The program has a comprehensive mental health crisis intervention services plan. The plan ensures the program responds to youth in crisis in the least restrictive means possible, to protect the safety of the youth and others, while maintaining control and safety of the center. The plan includes a notification and alert system, means of referral including youth self-referral, communication, supervision, and documentation and review of the crisis. The plan was reviewed and signed by both the program director and the designated mental health clinician authority (DMHCA) on April 2, 2019.

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

None of the seven youth in the review sample had the need for a crisis assessment. The program had one youth during the reporting period who required the completion of a crisis assessment and the program provided the youth's record for review. The youth was identified as being in crisis after sharing the loss of someone close to them during a group session. Immediately following the group, the youth was assessed using the crisis assessment instrument (MHSA form 023). The reason for the assessment, mental status examination and interview, determination of danger to self/others, initial clinical impressions, supervision recommendation, treatment recommendations, recommendation for follow-up or further evaluation, and notification to parent/guardian were addressed in the assessment. The result of the assessment was for the youth to remain on standard supervision. The plan was for the therapist to follow-up with the youth as needed if the youth needed to talk. The assessment revealed the youth was using their coping skills to deal with the loss. The program had mental health alert observation logs (MHSA 007) available if the youth was officially placed on supervision for crisis concerns. There was no need for an alert to be placed into the Juvenile Justice Information System as the youth was not placed on an elevated status of supervision after the completion of the assessment.

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

The program has a detailed emergency care plan which addresses mental health and substance abuse emergency care. The emergency plan was reviewed and signed by both the designated mental health clinician authority (DMHCA) and the program director on April 2, 2019. The plan contains all the required elements outlined in the Florida Administrative Rule 63N-1.0112 and includes the immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, staff training, and they will review each incident.

3.17 Baker and Marchman Acts (Critical)	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 the annual compliance review period; therefore, the 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 licensed medical doctor to serve as the designated health authority (DHA). 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 an advanced registered nurse practitioner (ARNP) for medical services. It was verified, through weekly physician weekly clinic list/sign-in sheets, the DHA is on-site weekly, every Monday, for two hours. Sign-in sheets were reviewed for November 1, 2018 through April 19, 2019. The program has an active agreement with a second medical doctor to provide clinical services, in the event the DHA is not available. An interview with the DHA validated they are on-site once a week to complete initial physical exams, sick calls, periodic evaluations/exams and referrals to specialists, as needed. The DHA is available twenty-four hours a day, seven days a week for emergency care and consultation, which is noted in the program's contract. The program has two full-time registered nurses (RN), one of whom serves as the director of nursing and one part-time RN. The program indicates they do not use the services of licensed practical nurses. 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 physician licenses are January 31, 2021.

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 the treatment protocols and Facility Operating Procedures (FOPs) validated the executive director (ED) and designated health authority (DHA) reviewed and signed them on March 14, 2018. Both parties documented their recent annual review of the FOPs on April 1, 2019. The FOPs outline the program's health care services. The nursing staff reviewed, signed, and dated the FOPs, treatment protocols, and procedures, on April 1, 2019. All policies were developed when the new provider took over the contract on April 2, 2018. No updates have been made to medical FOPs since development; however, when an update or change occurs all medical staff, to include the DHA, will sign an acknowledgement form indicating their review. Newly hired medical staff participate in on-the-job training and orientation with a comprehensive training plan. The practice was validated for one newly hired medical staff. 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 March 5, 2018 and again on April 1, 2019.

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

A review of seven youth medical records validated four maintained a valid Authority for Evaluation and Treatment (AET) and all were copies, with the word "copy" stamped on each. One youth was over the age of eighteen and signed a release of information document. The

remaining two youth were in the custody of the Department of Children and Families (DCF); one youth had a court order consenting to treatment and the other youth had a Department form HS 057 entitled, Limited Consent for Evaluation and Treatment.

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

The program has a policy and procedures to address parental notification 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 records revealed one youth was over the age of eighteen and was not applicable for parental notification. All remaining records contained the appropriate Department forms mailed to the parent/guardian regardless of verbal consent. These forms included: form HS 020 Parental Notification of Health-Related Care-General, and form HS 022 Parental Notification of Health-Related Care-Medication Management. All applicable records included verbal consents by the parent/guardian prior to starting a new medication. Two youth records reflected the need for written parental consent for an invasive dental procedure. One youth's health record verified their parent gave verbal and written consent prior to the procedure. The second youth is in Department of Children and Families (DCF) custody and a request has been sent to the court for the youth to receive the proper treatment. Currently the situation is not emergent, and the youth is not in pain; the doctor has stated the youth can wait for the dental procedure until after discharge in four months. One youth had notifications for medication changes and changes to their chronic condition. One youth was nineteen; however, they signed a form to release all medical documentation/information to their parent/guardian. The medical records for the youth under eighteen years of age, documented their parent/guardian was called and each of the calls were witnessed and documented. Regardless of telephone notifications, written notifications were sent to the parents/guardians for every notification for each youth. Three of the seven youth were involved with the DCF; however, parental rights had been terminated in only one of the three records. In one of the three DCF records; parental notification letters were being sent to the DCF worker but not copied to the parent; who still had parental rights. Four of the seven youth were taken off-site for treatment (dental and specialist) and notifications were made to parents by phone and in writing.

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

A review of seven youth medical records revealed five youth were on a psychotropic medication. Only one of the five youth was prescribed a new psychotropic medication post admission. The remaining four youth have had no significant changes, additions or discontinuations to their medication regimen. An additional two records were requested from the program for a total sample size of three. All three records contained documentation to show parent/guardian consent was obtained when the youth was placed on the medication and a notification with page three of the Clinical Psychotropic Progress Note (CPPN) was mailed out to the parent/guardian. All three parents/guardians gave verbal and written consent.

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

The program has a policy and procedures regarding immunizations which states an immunization history of each youth admitted to the program shall be obtained. A review of seven youth medical records validated each youth's vaccinations were documented on the Florida Department of Health Form DH 680, Florida Certification of Immunization. All the youth's vaccination records were verified within thirty days of admission. All youth immunizations were up-to-date except for one who needed a varicella vaccination. The parent's written consent was obtained prior to giving the youth the vaccine. The review team requested an additional two records for review; however, the program had only one additional record to show of a youth in need of vaccination. The clinical staff have made numerous attempts by mail and phone to obtain the parent's consent; however, the parent has not responded. The youth needs the varicella vaccine. None of the youth, nor parents/guardians requested a religious exemption of immunizations or refused consent for immunizations for any reason.

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

A review of seven youth medical records validated each youth record contained a completed Facility Entry Physical Health Screening (FEPHS) form and each was completed on the day of admission and completed by one of the program's registered nurses (RN). There were no youth medical records reviewed which documented the FEPHS form was completed by direct care staff; nor did the program have any records to provide as an example of the practice.

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

A review of seven youth medical records validated each youth was identified with a chronic illness upon or post admission and classified with a medical grade between three to five. The program has an internal alert system which medical staff update daily or as needed. All youth were entered on the internal alert system for each identified condition. If an allergy or medical condition may result in the need for staff to recognize and respond to the need for care the nursing staff add the information to the internal alert form/log and update the alert communication board. The alert form is updated daily or as needed and is available to staff at each shift briefing. The alert board is on the wall in the conference room which is where shift briefing, and department meetings occur. The board is covered with a screen which pulls down to allow for confidentiality when the board is not in use. The internal alerts matched each youth's medical record. Seven staff were interviewed, and all indicated they are notified of medical alerts daily during shift briefings, by viewing the communication/alert board and the alert log. One staff further indicated they also review the logbook for the alert information.

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

The program has a policy and procedures in place regarding youth orientation to healthcare services, which states all youth admitted shall be provided with an orientation to healthcare services within twenty-four hours of the youth's admission. It is the responsibility of the nursing staff to ensure proper orientation, 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. Each youth's health education record documented the date and orientation topic. Additionally, each youth's record contained a health care orientation form 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. A review of the program's healthcare contacts validated they were accurate.

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

The program's policy and procedures indicate 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 six youth were admitted with a chronic or suspected chronic condition and the DHA was notified by telephone upon admission for each youth. DHA notification was documented on the nursing chronological/notification progress note, and on a separate form entitled DHA and psychiatrist notification of admission form. The form document's the youth's medication, chronic conditions, and date and time of contact to the DHA/psychiatrist. None of the youth required emergency care during the admission process.

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

A review of seven youth medical records validated two of the youth had a change in physical custody, requiring a healthcare admission rescreening. An additional record was provided by the program to give a total sample of three. Each rescreening was completed on a new Facility Entry Physical Health Screening (FEPHS) form on the day of their return with one minor exception. One youth's FEPHS indicates it was completed in April 12, 2018; however, all collateral documentation shows this was a typographical error since the youth returned to the program April 12, 2019. All forms were completed by a registered nurse.

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

A review of seven youth medical records validated a new Health Related History (HRH) form was completed for each youth on the day of admission, which meets the required seven day timeframe. The most recent Department HRH form was used. All HRH forms were completed by

a registered nurse (RN). The designated health authority (DHA) reviewed each of the seven HRH forms which was documented on each of the comprehensive physical assessments (CPA). Each HRH was completed prior to the completion of the CPA for each youth.

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

A review of seven youth medical records validated each record contained a completed Comprehensive Physical Assessment (CPA). Each of the CPAs were new and were completed by the designated health authority (DHA). All CPAs were completed in their entirety and the Department's Problem List was reviewed and updated for each youth. Each CPA was completed in accordance with Florida Administrative Code 64M, documenting all required elements. One youth had all parts of the exam completed with no refusal or deferment. Two of the seven youth refused parts of the exam and their refusal was documented on the CPA along with their signature. Four of the CPA's documented a part of the exam was not completed because it was deferred by the clinician.

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

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

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

The program has a policy and procedures regarding tuberculosis screening (TB) and the control of infectious and communicable diseases. The policy includes the guidelines of Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA). A review of seven youth medical records validated each youth had at least one verified tuberculin skin test (TST) documented. The Tier I TB screenings were completed within twenty-four hours of admission and each youth was assessed prior to placement in general population. None of the seven youth's TST test results have expired.

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

A review of seven youth medical records validated each youth was referred for sexually transmitted infection (STI) testing on the day of admission. The test was ordered and administered on each youth's day of admission and 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 Sexually Transmitted Infection Screening form and on the ICD forms. Lab results were filed in the lab results section of each youth's medical record.

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

A review of seven youth medical records validated each youth was offered counseling, testing, and referrals for treatment for human immunodeficiency virus (HIV) infection. Each youth's record contained a signed HIV risk assessment form and the Department's HIV Antibody Test/Youth Consent form (form HS 015). Four of the seven youth refused testing. All three of the remaining youth received pre and post testing and each youth's results were in a sealed enveloped marked "confidential," which was placed in their medical record. The program utilizes Metro Wellness for all HIV testing and counseling. The program provided a copy of the Metro Wellness counselor's 500/501 certification issued by the local Department of Health in 2015. Documentation of pre/post-test counseling was documented on each youth's health education record. The program does not enter an alert for HIV status. None of the youth signed a release for the results to be provided to other individuals. Seven youth were interviewed, and each indicated they could ask for an HIV test.

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

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., which is in accordance with their contract. Only licensed, registered nurses (RN) conduct sick call. The director of nursing (DON) is contacted for guidance when a licensed nurse is not on-site for sick call. All sick calls for October 2018 through April 2019 were documented on sick call referral logs, using one form for each month. A review of seven records revealed only four youth have submitted sick calls since their admission. The youth records validated none of the youth presented with similar sick call complaints three or more times within a two-week period; nor did any of the youth complain of severe pain with which staff was unfamiliar. The completed sick call forms for each of the four youth were filed with the progress notes in their medical records in reverse chronological order. Seven youth interviews revealed six youth stated you can see a nurse immediately or within one day of submitting a sick call request form. The seventh youth indicated they had never submitted a sick call form.

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

A review of seven youth medical records found none of the youth were seen by non-licensed staff for sick call. Four of the seven youth were seen for a combined total of six sick calls. Each Sick Call Request (Department form HS 030) was documented in accordance with the Florida Administrative Code 63M and included information such as, but not limited to, vital signs, treatment, education, and follow-up procedures. Each of the youth signed the sick call form validating they were seen for the sick call. Each sick call form was filed in their respective medical record, in reverse chronological order and documented on each applicable youth's sick call index. Blank sick call forms are available to youth on their living unit and from staff.

One sick call encounter was observed during the annual compliance review with the youth's consent. The youth was brought to medical by a direct care staff, allowing the nurse to focus on the medical process, while the direct care staff maintained safety and security of the youth. The youth discussed his sick call complaint with the nurse and the youth signed the sick call form indicating the encounter occurred. No other youth were present, allowing the youth privacy. The youth was both interviewed and examined by the registered nurse (RN), while the youth was on a stool next to the exam table. The direct care staff remained just outside the medical door, with the door slightly ajar. Seven staff were interviewed and all seven indicated the nurse conducts sick calls.

4.20 Room Restriction/Controlled Observation	**Satisfactory Compliance**
All youth in Room Restriction/Controlled Observation shall have timely access to medical care, as required by the Department.	

The program has a policy and procedures in place to address youth in restricted housing. The policy indicates youth in restricted housing will be questioned daily for sick call complaints and nursing staff will visit the youth daily, provide required medication and document those visits in the youth's health record. Room restriction/controlled observation has not been used at the program within the annual compliance review cycle.

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

A review of seven youth medical records validated none of the seven youth were seen for episodic care by non-healthcare staff. An additional three records were requested from the program; however, the program has only 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, using 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.
The program has eight first-aid kits; one on each of the three living units, one in the administration front office, one in the kitchen, and three in master control (two of which are used for transportation). During the annual compliance review, five first aid kits were opened and found all necessary items were in each kit and no items were expired. First aid kits are inspected weekly by a registered nurse (RN) and documentation was reviewed for the last six months to validate the practice. Seven youth were interviewed and asked if they could see a dentist for tooth pain or see a doctor if needed, and all youth indicated they could.

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

The program has one automatic external defibrillator (AED), which was observed, and the instructions and guide were enclosed in the AED box. The program's AED is stored in master

control, and accessible to all staff. Instructions are also kept in the medical clinic for staff to obtain if needed. The nurse conducted an AED test in front of the review team member. Battery and pad checks were completed for the AED, and found the battery expires July 2022 and the pads expires May 2021. The batteries were installed January 11, 2019 and the pads were installed April 2019. A review of the program's emergency equipment monthly inspection log sheets for the last six months validated a registered nurse checked the AED monthly.
All emergency drills and trainings for direct care staff were reviewed for the past six 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 cardiopulmonary resuscitation (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. Each staff have also been provided a copy of the emergency phone list.
When a youth requires the use of an epinephrine auto injector, all healthcare and direct care staff must be trained on the administration of the epinephrine auto injector. A review of fourteen training records revealed all staff have been trained in the use of an epinephrine auto injector. A review of the medical drills found program staff participated in at least one drill demonstrating the use of the epinephrine auto injector. There have not been any youth within the last six months who were prescribed an epinephrine auto injector nor were there any incidences of needed use. Seven staff were interviewed and indicated they could call 9-1-1 if there was a medical emergency.

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

A review of seven youth medical records found four have required referrals for off-site care and zero required off-site emergency care or first-aid. Three of the youth required notification of care to a parent/guardian. One of the guardians was the Department of Children and Families (DCF). Notification to the parent was made verbally and in writing. One of the four youth was over the age of eighteen. All notifications were documented in the nursing progress notes and on the appropriate notification letter/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). All records contained documentation of a physician orders done 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 healthcare record when applicable. The youth received timely follow-up care with the DHA, as needed.

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

A review of seven youth medical records validated six youth were identified with chronic conditions upon admission. One of the seven medical records validated the youth was not identified with any chronic conditions at the time of admission; however, they were identified with chronic condition after admission and the information was added to the internal alert log. Each of the youth were placed on the internal alert log. Periodic evaluations were conducted, as required, for each youth and were maintained in each of the youth's Individual Healthcare Records (IHCR) and there was no indication of lapses in care or missed periodic evaluations for

any of the youth. 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 program's program director was interviewed and confirmed the program's process. The program's DHA was interviewed and indicated they are informed of important information on a weekly basis and they meet at least quarterly with program administration.

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

A review of seven youth medical records validated six of the youth were on medications upon admission. A review of each youth's Facility Entry Physical Health Screening (FEPHS) form validated medications were verified and the designated health authority (DHA) was contacted by telephone on the day of each youth's admission; licensed healthcare staff documented the process on the nursing chronological progress notes and on a separate form entitled DHA and psychiatrist notification of admission form. 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 youth are admitted to the facility and licensed health care staff are not on duty.

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

A review of seven youth medical records validated all seven youth were on medications. Six of the youth were on medication upon admission and were continued on the medications at the direction of the designated health authority (DHA) and/or psychiatrist. The remaining youth was prescribed new psychotropic medications post admission. Each youth's order was documented on a physician's order form. Two of the seven youth were given over-the-counter medications not listed on the Authority for Evaluation and Treatment (AET), and both were given the medicine in accordance with approved protocols. The physician's order, as well as the chronological notes, documented each youth's medication regimen.

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

All medications are secured either in a locked medication cart and/or locked cabinets within the locked medical clinic, which is inaccessible to youth. Observations found all medications were securely stored within the medical clinic. All controlled medications were stored in a separate, secure box located within the locked medication cart. 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 contracts with 1st Choice Pharmacy for all medication services. All non-controlled medications are returned to the pharmacy through the contracted pharmacy consultant. The nurse explained the process for disposal of expired or discontinued medications; the

medications are either returned to the pharmacy for credit, if applicable, or destroyed on-site in the medication disposal container. The program also 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.

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

All medications, sharps, and over-the-counter (OTC) medications are counted/verified weekly using a perpetually inventory. Syringes and sharps are kept in locked cabinets within the medical clinic. An inventory of three sharps, over-the-counter (OTC) medications, and three youth medications were conducted with the nursing staff and all counts matched the inventory. A review of the program perpetual inventories of medications and sharps, from the past six months were reviewed and no discrepancies were noted. The program has a process outlined in their policy and procedures for reporting inventory discrepancies.

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

The program 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 1st Choice 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 by two staff either the medical staff and/or a shift supervisor. The program had seventeen youth prescribed a controlled medication during the annual compliance. 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 discrepancies noted.

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

The program utilizes the Department's Medication Administration Records (MAR). Seven youth medical records were reviewed, and each documented the required elements on the MARs and validated each youth received medication, as ordered. The MAR does not include the youth's photo; however, a large photo of each youth is in the current MAR binder in the front of the current MAR for each youth. Nursing staff reviewed and documented side effects weekly for each of the MARs reviewed. When applicable, start and stop dates of medication were documented on the MAR. None of the seven youth refused medication; however, one youth refused their eyeglasses and the refusal was documented on a refusal form as required.

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

A review of seven youth medical records validated none of the youth required parenteral medication. Medication administration for blood sugar checks were observed for three youth during the annual compliance review. The clinic, where medication administration was conducted, is clean and organized and the nurse always had control of the medications and medical cart. The youth approached the licensed staff in a structured manner. The licensed staff verified the Five Rights of Medication Administration and the Medication Administration Record (MAR) prior to the medication administration. The staff verified the youth swallowed their medication by the performance of a mouth sweep and by asking the youth to cough. No medication was observed to be pre-poured. Seven youth were interviewed and they all indicated a nurse administers medication. Each youth verified the program's practice in a verbal description of the program's process. Seven staff were interviewed, and all indicated the nurse provides medications to the youth.

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

The program has a policy and procedures in place which allow trained non-licensed healthcare staff to assist youth with self-administration of oral, topical, and inhaled prescribed medications when a licensed nurse is not available on-site. A review of training documentation shows seven delegated non-licensed healthcare staff were trained in the administration of medication by the registered nurse (RN). A review of seven youth medical records revealed none of the youth were provided medication by non-licensed healthcare staff. The program provided three additional records for review. A review of all medication administration records for the three youth reveal both the staff and youth initialed the Medication Administration Record. None of the youth refused their medication. Staff are required to follow the five rights of medication administration when administering medication; however, during annual compliance review, there was not a period where non-healthcare staff administered medication to youth; therefore, observations were unable to be made. Seven youth were interviewed and they all indicated a nurse administers medication. Each youth verified the program's practice in a verbal description of the program's process. Seven staff were interviewed, and all indicated the nurse provides the medications to the youth.

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

The program has a policy and procedures in place to address the comprehensive process of monitoring psychotropic medication. A review of seven youth medical records validated all the youth required medication monitoring for psychotropic medications. Six youth entered the program on psychotropic medications and one youth was prescribed the medication post

admission. The designated health authority (DHA) was notified upon admission for each youth, despite being admitted on psychotropic medications, as part of the program's admission process. All seven youth were referred to the program's contracted psychiatrist for evaluation. Seven records were reviewed for the initial diagnostic interview and each were conducted within fourteen days of admission. Each evaluation contained the required elements. Five youth required monthly monitoring of Tardive Dyskinesia and these monitoring's were documented as required, in each of the youth's health records. There were no standing orders for any psychotropic medications, emergency treatment orders, or pro re nata (PRN) orders for psychotropic medications. Each of the youth received monthly medication monitoring, documented on the Clinical Psychotropic Progress Note (CPPN).

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

The program has infection control procedures in place which includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as required by Occupational Safety and Health Administration federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. A review of the program's infection control procedures (approved January 23, 2018 and updated March 1, 2019) validated all required elements were included. Upon review of the program's policy and procedures and the exposure control plan, it was validated staff have access to Hepatitis B immunizations and protective equipment. All staff are trained in infection control procedures. There were no instances where the local health department, CDC, and/or Central Communications Center should have been notified for an infectious disease.

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

The program has a policy and procedures in place for infection control education. The education plan requires all staff to complete pre-service and in-service training and requires all youth to complete infection control education in accordance with the Centers for Disease Control and Prevention (CDC) guidelines. Fourteen staff training records were reviewed (seven pre-service and seven in-service) for infection control and exposure control training. All training records validated each staff received exposure control training in 2018. Sign-in sheets provided by the program indicates all staff were trained on the infection control/exposure control plan June 28, 2018. All seven reviewed youth medical records contained documentation of infection control education, which included prevention of communicable diseases and prevention of blood-borne pathogens. All education was documented on each youth's individualized health education record.

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

The program's exposure and infection control plan is combined and was created on January 23, 2018 and updated March 1, 2019. A review of the program's exposure and infection control plan found the plan included risk assessments, methods of compliance, and a comprehensive process for needle stick post-exposure evaluations. The plan is written in accordance with Occupational Safety and Health Administration standards. The program has not had any youth or staff who experienced a facility or occupational exposure during the review period. The executive director indicated the exposure control plan is accessible to all staff in their office, as well as in the medical clinic. The plan is reviewed annually with all staff. The program's policy and procedures indicate medical records, for youth and staff who have experienced a facility/occupational exposure, shall be maintained in a confidential manner and kept with the program's human resource department. Through an interview with the program's nursing staff, it was verified there were no reportable cases of infectious disease needing to be reported to the local county health department and/or Centers for Disease Control and Prevention, nor were there any instances involving the quarantining or hospitalization of at least ten percent of the total population of youth or staff, or six individuals, whichever is less.

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

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

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

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

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures in place to address youth supervision. The program's staff to youth ratio during daytime activities is one staff to eight youth; and one staff to ten youth during night time sleeping hours; and one staff to five youth during transports/off-site activities. The program has a program schedule posted throughout the dormitories and the facility. The schedule indicates the youth participate in school, hygiene, meals, groups, recreation/leisure and line movement. During the annual compliance review, daily observations were conducted of various youth activities to ensure staff to youth ratio was being followed and to ensure staff were actively supervising youth. Review team members observed youth line movements and daily activities, which included recreation, school, breaks/hygiene, groups, and lunch. Each of the observed activities revealed the staff to youth ratio was being followed, all youth were controlled and orderly, staff were positioned to response, and positive interactions were occurring. Daily random informal interviews were conducted with eight direct care staff regarding the number of youth under their supervision and all staff were immediately able to provide the correct count. Seven staff were interviewed, and all were able to explain the procedures for when a count could not be reconciled. All staff further stated the movement of youth is stopped and a re-count is conducted until an all clear is given and each youth is accounted for.

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

The facility has a written policy and procedures to address the program's behavior management system (BMS), and the policy includes the requirements for staff training. The program's BMS consists of four phases numbered from one to four. The BMS is designed to reduce anti-social behaviors and reinforce positive pro-social behaviors resulting in the receipt of incentives for positive behaviors and consequences for negative behaviors. A review of seven youth case management records confirmed at each youth's orientation they received a youth program handbook. The program uses phase level evaluation forms to track and manage each youth's daily and weekly earned points. The BMS clearly details the four phases and how a youth can earn points based on program rules adherence, cleanliness and maintenance of dormitory rooms, participation in groups, and school, and by displaying appropriate communication and behaviors with peers, staff, and visitors. The program BMS ensures its utilization from staff is fair, effective, and consistent. The program's BMS includes an application ratio of four positive reinforcements to each negative reinforcement. During the annual compliance review, several

observations from the review team confirmed the program staff consistently adhere to the elements of the BMS. The program's BMS covers the promotion and protection of youth rights through readily accessible grievance forms, which a youth could complete and submit. The program's grievance forms are entitled, Conference Request forms. The form offers the opportunity for youth input on various topics they may want to change or request additional services. In a case where a youth disagrees with losing of assigned points, the point cards are reviewed by the program director, with the youth and staff present who reduced the youth's points. During the annual compliance review, a facility tour was conducted and the program's BMS system was posted throughout the program. A review of seven pre-service and seven in-service training records revealed all staff received training on the program's BMS system at the time of hire and then again annually. An interview with the program director was completed and they were able to describe the program's BMS and describe how it implemented and maintained by staff. Seven youth and seven staff interviews were completed, and all individuals were able to articulate their understanding of the BMS and they all knew the steps to progress to the next level in the program. All seven staff reported daily, weekly and monthly distribution of youth incentives, such as snacks, movie night, canteen access, food and off-site outings are distributed daily, weekly and monthly. Five of the interviewed staff indicated items cannot be taken away from youth for inappropriate behaviors. Two of the staff indicated items such as points and loss of incentives are taken from the youth as consequences for inappropriate behaviors.

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 policy and procedures addressing the behavior management system (BMS), infractions, and applying consequences for any youth displaying negative behaviors. BMS staff training is provided to all staff and each staff is evaluated on their implementation and monitoring of the system on their performance evaluations. A review of seven staff pre-service and seven staff in-service training records revealed all staff were trained in the program's BMS. The program's BMS also includes a joint agreement between the program and education department for the inclusion and practice of the BMS during school hours. The program administrative staff meets with staff who are implementing the BMS and ensures they are tracking the youth's points correctly, to ensure youth remain on task and are progressing in the program. The monitoring of point cards is discussed during staff shift briefings, monthly supervisory meetings and treatment team meetings. The program does not use room restriction as an outcome for negative behaviors. The program's BMS is not used to increase the length of stay of the youth, deny youth basic rights or services, or promote the use of group punishment. The program uses four different phases, and a youth's progress through the phases is based on positive performance and completion of program tasks. The BMS for each youth is tracked on a phase level evaluation forms and managed for each youth on a daily and weekly basis concluding each day with earned or lost points. Each dormitory has a youth mayor, who is on

the program's youth advisory board; the mayor's role is to maintain each youth's point sheets in a binder, which allows the youth to have unhindered access to their cards and they can see how they are progressing. The point results are published to the youth and discussed in treatment team meetings. The BMS notes when a youth exhibits inappropriate behavior staff will implement the use of discipline referrals, special treatment meetings, and loss of points as consequences for those behaviors. Seven youth were interviewed about the program's BMS and the receiving of consequences. Four of the seven youth indicated they receive three prompts to change their behavior before staff give them a write up or they receive consequences for their inappropriate behavior. The fifth youth indicated the staff do not give out consequences fairly and some youth are given more chances to change than others. The sixth youth indicated they really could not give an example because they have not received any consequences and they refuse to participate in their treatment plan. The seventh youth indicated security alerts, restrictions, and Protective Action Responses are some of the consequences used by the program. The youth further stated staff are not fair and consistent when giving out consequences. The seven interviewed youth indicated as part of the BMS they can purchase food with their points from the canteen, earn the privilege to go to the movies and on other off-site activities. None of the seven interviewed youth indicated youth can punish other youth. Five of the seven youth indicated staff are consistent in the use of rewards because the supervisors provide the youth with the rewards they earn. The sixth youth indicated they do not receive rewards and the final youth indicated they do not think staff are consistent because some youth get more chances than others. The seven youth were asked to rate the program's BMS and one youth indicated it was very good; one indicated it was good; one indicated in was very poor; and four indicated it was fair. Seven staff were interviewed and during the interviews they all indicated youth can explain their behaviors and why they acted inappropriately to the staff disciplining them, to the treatment team, and to the administrative staff, if they feel the staff implemented the BMS incorrectly. The seven staff indicated they are all provided feedback on their implementation of the BMS when they receive their annual evaluations, at shift briefings, staff meetings, and throughout the day by their direct supervisor. An interview with the program director indicated youth consequences are monitored through meetings which focus on discussing behavioral program infractions. During the meetings, members of the treatment team discuss all youth program infractions and discuss the consequences which will be administered through the facility BMS, because of the program rule violation.

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

The program has a written policy and procedures regarding the completion of ten-minute checks. The program has thirty-eight cameras designated throughout the property, and all were observed to be operable during the annual compliance review. Video footage is monitored by the assistant program director. The camera system includes three digital video recorders (DVR) systems, which has a thirty-day video storage capacity. The DVR which records all three youth dormitories was replaced on April 16, 2019, due to a bad hard drive. The program staff complete ten-minute room checks all times youth are scheduled to be in their rooms and they document the checks on an accountability visual check sheet. The sheet documents the name of each youth, room number, and time of conducted checks with a corresponding staff initial and signature of completion; in addition, a shift supervisor initials and signs they have reviewed each

sheet. The sheets are maintained in a binder divided by month. A sample of eight security tapes and the corresponding ten-minute visual check sheets were verified for completion of ten-minute checks across the three dormitories. The sample included various dates within the last eleven days from all three scheduled shifts. The video footage displayed staff were positioned accordingly, ensuring fidelity was met, and they completed each check every eight minutes and documentation supported the checks were conducted in real-time. Seven staff were interviewed; six staff reported checks are completed every eight minutes and one staff indicated every ten minutes.

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

The program has a policy and procedures in place regarding youth census, counts and tracking. Throughout a twenty-four-hour period, on-site direct staff and shift supervisors conduct and document in a facility logbook formal youth counts and unannounced Prison Rape Elimination Act (PREA) count. In addition, to the inclusion of documenting informal counts for emergencies, youth movement, disturbances or missing youth. During the annual compliance review, a sample of facility logbooks from eight randomly selected dates between October 2018 and April 2019 were reviewed to ensure census and counts were completed. All eight reviewed dates highlighted the daily youth census, counts conducted, and daily youth activities tracking were documented consistently. The logbook also included youth as head counts, youth movement, new admissions, releases, emergencies and youth temporarily away from the program. Observations during the annual compliance review confirmed staff were conducting random counts of youth. Seven staff were interviewed, and three indicated counts are completed hourly, while four indicated every thirty minutes. Five out of seven staff noted discrepancy counts require a recount be conducted until all youth are accounted for and the count is clear. Three of the interviewed staff noted counts are conducted during and after emergencies.

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 in place to chronologically record daily youth activities, events and incidents into a central logbook. The facility logbook is maintained in master control throughout the day. The facility logbook is a spiral bound book with a dated cover with pre-printed sections and has page numbers on the bottom of each page. The sections in the logbook are completed by program staff, which record shift report updates, security perimeter checks, youth movement and counts, statistical information on admissions, discharges, transports, Central Communications Center (CCC) or Florida Abuse Hotline calls, emergencies, and law enforcement requests. The sections in the logbook also record unit issues, youth alerts, incidents and shift summary notes. The outgoing shift manager is responsible for the completion of all sections of the logbook, which includes the signing and recording of shift report reviews. Five program facility logbooks were reviewed from October 2018 through April 2019 for various entries. All reviewed entries contained the required elements and were legible with a brief description of the event, date, time and signature of the person documenting the information. One logbook was taped at the edges, and another logbook had the back cover and a few pages before the back cover coming loose from the spiral; however, both logbooks did not have any missing pages. During the review, a team member observed shift change and a review of the logbook by incoming shift staff was verified. The staff were verbally briefed by the outgoing shift supervisor about youth alerts and concerns prior to the start of duty. The program supervisor makes a copy of each shift report from the logbook, which acts as a shift report for the program. The supervisor then places the copies in shift report binders maintained on each youth dormitory for the staff to refer to as needed during their shift. Observations confirmed all three dormitory supervisory closets contained a shift report binder with copies of the shift reports from at least the last seventy-two hours for staff to refer if necessary. A sample of three Central Communications Center (CCC) calls were selected, and all were documented in the logbook.

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 use, loss and damage of keys on the property. Upon entering the program there is a tracking system of all incoming and outgoing personal keys of visitors and staff documented on sign-in and sign-out sheets. When a visitor submits a set of personal keys they are provided a numbered badge, which corresponds to a numbered peg in the key control box, where their keys are maintained while they are at the program. Upon leaving the program the visitor will turn in the badge for their personal key. The staff ending their shift will sign-in their assigned keys and sign for their personal keys. All

personal keys are stored on numbered hooks in a locked key cabinet in the front administration office. The key control system is monitored by the main master control operator and includes a daily sign-in and sign-out process on a key control log sheet. Master control is open twenty-four hours, seven days a week. The information recorded on the facility key log was observed to be dated, timed and includes the key ring assigned, signatures of the staff receiving and providing the keys.

The distribution of keys is the responsibility of the shift supervisor or assigned designee for master control. Restricted keys are required to be signed-in and signed-out and distributed to specific staff. These keys are maintained in a separate locked cabinet in master control due to their access to staff records, the medical clinic and storage, youth records, personnel records and evidence property storage, as well as the canteen closet. The assigned primary holders of permanent keys are administration staff, the program director, assistant program director, and maintenance. Temporary key assignments are signed-in and signed-out at master control by staff and provided for the shift, which include access to the dormitories, school classrooms, and the cafeteria. During the annual compliance review, the team observed various exchanges of keys between the designee assigned to master control and staff, as well as key exchanges between the front administrative staff at the entrance for visitors and staff beginning or ending their shift. Daily observations verified the program has implemented and followed their key control policy as it relates to keys not in use, restricted keys, key assignments, key inventory, key tracking and securing of personal keys and documenting all processes on the key control log sheet. Three random staff key checks were completed, two direct-care staff and one therapist, and no personal keys were found on the staff, and each staff had their assigned keys for the shift. A review of the key control log from fourteen randomly selected dates between October 2018 through April 2019, was reviewed, and all required elements were found with two exceptions; the logs do not consistently record a.m. and p.m. next to the time the keys are given out and returned and the date block does not always indicate the year.

Seven staff were interviewed about key control and they all indicated personal and visitor keys are a part of an exchange process for a facility key or badge, and keys are securely stored in master control and facility administration. All seven staff reported youth do not have access to keys. Six staff reported there is a key log tracking system in place and when keys are damaged they are replaced. Three staff noted when keys are missing it is reported to master control. An interview with the assistant program director verified the process for replacing missing, lost or damaged keys. The process of lost or missing keys, includes immediately shutting down the facility to complete an emergency searches of all youth and designated areas; no one will be allowed in or out of the facility until the keys are located. Additionally, the program director and physical plant manager will be notified; and a report to the Central Communications Center (CCC) will be done to advise about the lost keys. If the keys are not located, all door locks on the property will be changed by an approved outside vendor with supervision and assistance from the physical plant manager. Damaged keys are reported to the program director and physical plant manager, who will make the necessary replacement of keys.

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

The program has a policy and procedures in place to monitor, prevent, and address contraband entering the facility. On August 2015, the Florida Department of Juvenile Justice (DJJ) issued a policy regarding its recommended guidelines on defining contraband. During the annual compliance review the programs policy and procedures were verified by the reviewer, and they showed an alignment with all the required elements of the Department's guidelines on contraband materials and items. During a new hire orientation an employee handbook is provided to each staff member and there is a section which defines and lists prohibited items and materials considered as contraband. New hires are oriented from the handbook on possession of contraband and types of disciplinary action which could be taken if they are found in possession of it. New youth admitted to the program are also oriented on and provided a youth handbook, which lists the prohibited items and materials considered contraband. During the orientation the youth are informed of behavioral consequences, in accordance with the Behavioral Management System (BMS) if they are found in possession of contraband. In the case of a youth contraband violation a special treatment team referral is written up by staff, and then the youth meets with administration to discuss the incident and come up with a consequence. Incoming and outgoing mail is searched by staff in the presence of the youth to govern the control of contraband. The program's staff documents all mail transactions for incoming and outing mail and records the information in two separate binders on the program's correspondence log or on each youth's personal correspondence log. Visitors to the facility are searched by staff and are subject to a pat down or frisk search by a designated staff of the same sex. Program policy requires staff to confiscate any items deemed to be contraband, document the findings on the visitor search log and dispose of the contraband accordingly.
A review of eight randomly selected dates from the last six months of room search logs was completed for compliance with contraband procedures. Findings show the program staff consistently conducts unannounced random weekly room searches across all three dormitories for contraband, and if found it was then confiscated and disposed of. Each log documents the date of search, list of contraband found, reason for confiscation, manner of disposition, and the staff conducting the search. Some of the prohibited items found by staff in youth rooms were snacks, pens, extra pillows, and newspapers. Additionally, a review of the past six months of visitor search logs was conducted, which were consistently completed, and findings were reported on the required log. The program policy indicates the procedures of documenting all searches must be recorded in the facility logbook; however, a review of the facility logbook for

eight randomly selected dates showed no record of the searches being conducted. During the debriefing process, the program acknowledged the review team findings and agreed they are not following their policy of logging searches in the facility logbook; however, they are conducting the searches in accordance with the Florida administrative code. Perimeter checks are completed daily on each shift by a designated staff and documented completion is recorded in the facility logbook, and the reviewer verified the checks were being completed. On each shift youth searches are to be conducted continuously at each movement, which includes youth exiting and entering the facility regardless if it is for transport, meals, education, recreation, group and/or medical services. During the annual review, the reviewer was able to observe multiple searches for contraband. If illegal items defined in Florida Statutes are found law enforcement will be notified, a report to Central Communications Center (CCC) will be placed, notification to the program director will be done, and the incident will be documented in the facility logbook. Since the last annual compliance review there has been no findings or reports of illegal contraband. An interview with the program director verified the program's policy and procedures governing, preventing, and addressing unauthorized and illegal contraband.

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 written policy and procedures for searches and full body visual searches. During the annual compliance review, daily observations by the reviewer were conducted for assurance of searches being completed in accordance with the program's policy and procedures. Observations concluded youth searches were consistently completed by staff before and after youth transports, youth transition, line movement, entering/exiting dormitories, before and after breaks, groups, lunch, and education. Observations additionally confirmed all searches were conducted with dignity and respect by a same sex staff. During the review, the reviewer was not able to observer a full body search during an admission, nor searches of youth who had access to tools and equipment. Seven staff were interviewed about searches and they all indicated youth are searched after every movement. Five of the staff also indicated youth are searched when returning from off-campus activities/outings. One of the staff further indicated youth are searched when contraband is suspected. Seven youth were interviewed about when they are searched and six indicated when returning from off campus activities and outdoor activities; seven indicated when items are missing, after visitation and meals; and three youth indicated they are searched after work detail. The Department of Juvenile Justice Protective Action Response (PAR) has guidelines for full body search procedures, which the program is actively implementing. An informal interview with the assistant program director indicated all direct care and administrative staff are Protective Action Response (PAR) certified and trained on how to conduct proper searches.

5.10 Vehicles and Maintenance	Satisfactory Compliance

All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment so they may be operated in a safe manner.

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

The program has a written policy and procedures for vehicle maintenance and assurance of vehicles containing safety and emergency equipment. During the annual compliance review, there was one observation of a scheduled youth transport for an off-site medical appointment. The vehicle used included the appropriate number of seat belts, one first aid kit, a seatbelt cutter, window punch and fire extinguisher. An inspection was conducted on two secured vehicles one fifteen passenger van and one mini-van both were non-caged vehicles. Each vehicle was equipped with a seat belt cutter, a window punch and a secured fire extinguisher. Due to the nature of the items in a first aid kits, they are stored in master control and retrieved by staff prior to the transport and placed in the vehicle while transporting the youth. Both vehicles were observed to be clean and in good condition, seat belts were in working condition each vehicle had the appropriate amount of seat belts.

The program vehicle logbook, which documents all processes of transporting youth is secured in master control and only removed to a vehicle for scheduled use. The assistant program director also notifies the program director by text when transport is departing the facility. The reviewer observed in master control where vehicle keys are maintained, and they are secured in a locked cabinet. A review the annual safety inspection for the program's two vehicles were current. The 2017 van received an annual inspection on June 26, 2018, and the 2016 mini-van on March 6, 2019. The program has a preventative maintenance binder, which contains invoices of repairs, maintenance and safety inspections, which verification showed documentation of deficiencies and corrections completed.

5.11 Transportation of Youth	Satisfactory Compliance

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

The program has a written policy and procedures regarding the transportation of youth. During the annual compliance review, there was an observation of transport to an off-site medical appointment. The observed youth transport included two staff, one male (the driver) and one female, and 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. The female staff held unto the youth documentation and the first aid kit was obtained from master control. A full inspection of the vehicle was completed by the male staff prior to the transport and the youth passenger area doors of the vehicle could not be opened from the inside. The youth was escorted into the vehicle with help from staff. The female staff sat positioned behind the youth to ensure safety and security. All passengers were observed wearing seatbelts. The reviewer verified all staff designated and listed on the

program's approved drivers list as a transporter had a valid driver's license. Seven staff were interviewed which indicated personal vehicles are not used to transport youth. Seven staff further stated they are provided a program cellular phone for use during youth transports.

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

The program has a written policy and procedures regarding weekly safety and security audits of the physical plant and perimeter. A review of the program's policy verified all the requirements of Florida Administrative Code 63E-7.013(5) are met. Weekly safety and security audits are to be completed every seven days and are the responsibility of the physical plant manager and assistant program director. The weekly audits are reviewed by the program director. The program uses a security audit and safety inspection form for documentation of weekly audits and presenting deficiencies. Major deficiencies found are reported to the program director and a corrective action plan is created until the deficiency is corrected. The program director submits request to the Department of Juvenile Justice (DJJ) for major maintenance work orders on the physical plant. The physical plant manager is responsible for completing all applicable deficiency work orders submitted. The weekly safety inspections binder, was reviewed for last six months prior to the review and it supports the program has consistently completed weekly facility inspections completed by the assistant program director or physical plant manager and reviewed by program director on the same day as inspection. Documentation reviewed shows compliance with documenting required deficiencies and resolving them. During the annual compliance review, the program education room number one door was observed to be broken. A review of the facility security audit and safety inspection report dated April 2, 2019, verified a work order is in place for a new door cylinder; however, the part has yet to arrive at the program for the physical plant worker to fix the door. An interview with the program director indicated the program has not received any deficiencies regarding the program's physical plant during the review cycle.

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

The program has a written policy and procedures regarding the management and inventory of tools (Class A and Class B) and kitchen utensils used within the facility. During the annual compliance review, the Facility Operation Procedures were reviewed, which indicates the classification of Class A, Class B and prohibited tools, in addition, to the process for replacing stolen and missing tools. The physical plant manager is primarily responsible for management and inventory of tools, with the assistant program director overseeing the process. Tool inventory is maintained in a binder, which documents, daily use sign-in and sign-out, monthly and semi-annual inventories and annual tool inspections. The reviewer completed an inventory inspection of all Class A kitchen utensils and eight tools and all tools were accounted for. Outside on the property there is a small room towards the back of the property, where the physical plant manager stores Class A tool tools on a shadow board layout. The facility also has a tool binder, which includes colored pictures of the tools for further reference. The reviewer was escorted by the assistant program director to the location of the stored tools, and upon arrival the door was locked and secured. The tool room was neat and clean with no hazards or prohibited tools found. Eight tools were identified in comparison to the maintenance tool

inventory and audit log completed on April 3, 2019. All eight tools were accounted for, secured and marked accordingly. The reviewer completed an inspection of all knifes and compared it to the monthly and daily use knife inventory accountability logs for the past six months and all items were accounted for. All Class A kitchen utensils were secured and locked in a cabinet in the kitchen. Seven pre-service staff training records revealed all staff received tool training upon hire. Seven in-service staff training records revealed each staff member received yearly training on tool management. Seven interviewed staff indicated the only tools the youth can use are mops and brooms.

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 addressing youth tool handling and supervision. The program procedures includes staff and youth training in usage of Class B tools. A review of seven staff pre-service and seven in-service training records verified all staff were trained in tools management. A review of seven youth case management records indicated youth are trained in tool usage during the orientation process and the training could be verified by the youth's signature on their orientation packet. The program procedures include provisions for youth to use class B tools following the completion of a risk assessment form, which determines the youth's risk of harm to themselves or others. The program has a central binder which stores all youth's monthly risk assessments. A review of the monthly risk assessments for the review period, revealed updated risk assessments were completed for all seven reviewed youth records. Risk assessment findings indicate the youth's ability to use Class B tools; such as, mops and brooms for clean-up activities. The assistant program director indicated in an informal interview 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. An interview with seven youth indicated six stated they can use mops and brooms. The seventh youth indicated youth are not allowed to use 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 addressing outside contractors entering the program. The program policy prohibits the use of picture taking and video recording devices while contractors are on the property. Upon program entry 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 an area for the assurance tools are removed from the program when the contractor leaves. The form is signed by both the contractor and the program staff inventorying the contractors' tools. The physical plant manager serves as the liaison between the program and contractors, and one of the roles is to escort and stay with the contractor's while they are on-site. The work areas used by contractors are searched after the project has been completed to ensure no tools are left behind. All contractor forms are turned into the program director for review within twenty-four hours of the contractor's visit. The program maintains a central binder in master control which includes the contractor sign-in and sign-out forms. The binder also includes tool inventory sheets for tools used while

the contractor was on the property. The contractor's invoices, sign-in logs and tool inventory sheets were reviewed for the six months prior to the annual review and no discrepancies were noted. All logs included instruction sheets to the contractors and all required elements and signatures were on each form. All contractor forms were turned into the program director for review within twenty-four hours of the contractor's visit.

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

The program has a written policy and procedures regarding fire, safety, and evacuation drills. The program provided the annual inspection from the fire marshal, which was completed on December 21, 2018 with one violation found regarding corroded sprinkler heads. The program received the final report from the fire marshal on March 29, 2019. The program's fire sprinkler heads are corroded in the sally port area and youth dormitory bathrooms and need replacing. The deadline to correct the violation from the fire marshal was listed as May 1, 2019. The program submitted a major repair and maintenance work order to the Department on April 3, 2019, for replacement of sprinklers and trim plates in the sally port and dormitory bathrooms. The program received two quotes for repairs in March 2019. During the annual compliance review, observations confirmed egress plans are posted throughout the facility. The program has procedures in place to ensure youth and staff are prepared for immediate response in the event of an emergency or disaster. The program policy requires drills to be conducted at least one time monthly on each shift in addition to a Continuity of Operations Plan (COOP) annual drill. A review of the program's last four quarter drills indicated across all three shifts there were a total of thirty-five fire drills, five safety drills, two evacuation drills, and three disaster drills. Amongst these drills six are considered COOP drills. There was no supporting documentation attached to the April 2018 second shift drill or the February 2019 first shift drill. During the debriefing process, the program acknowledged the reviewer's findings for the missing attachments. All other reviewed drills verified safety and evacuation drills were conducted as required by the program. All drills were documented with all required elements; such as, noting the type of drill, date, time, scenarios, response and critique. A review in the program facility logbook on five randomly selected dates covering various shifts confirmed the program documents all fire drills.

Seven youth were interviewed and they all indicated they were aware of what to do in the case of a fire. One youth indicated fire drills are conducted about four times a month; three youth indicated fire drills are conducted two or three times a month; one youth indicated a fire drill was recently conducted; one youth indicated they thought fire drills happened monthly; and one youth indicated they really do not know because they have been involved in so many. Seven staff were interviewed and they all indicated they had participated in a fire drill and weather drills in the last twelve months. Two staff further indicated they participated in a major disruption drill, and five of the staff also indicated they had participated in an escape drill. The program director was interviewed, and they indicated the program conducts monthly COOP drills on all three shifts, additionally the program conducts monthly fire drills on all three shifts, monthly medical drills for all three shifts, and monthly mental health/suicide drills on all three shifts.

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

The program has a policy and procedures in placed regarding a disaster plan and Continuity of Operations Plan (COOP). The COOP incorporates all the following: program disturbances, fire prevention, fire incidents, chemical spills, severe weather disasters, flooding, evacuations, bomb and terrorist threats. Additionally, the COOP includes alternate housing arrangements, staff responsibilities and roles, provisions for continuity of care and custody of youth, required supplies and equipment needed, and provisions for public protection. The program has a copy of the COOP in master control and the program director's office. The staff have readily available access to the plan, and it is posted in the staff breakroom and conference room. The program's COOP was signed on May 03, 2018, by the Department of Juvenile Justice central region residential director. During the annual compliance review, a new submission of the program COOP was approved by the Department with all required parties' signatures on April 24, 2019. The reviewer observed where the emergency food supplies were stored, which is in a storage container on-site. An interview with the program director confirmed the locations of the COOP plan throughout the facility.

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 regarding the storage and inventory of flammable, poisonous, and toxic items and materials. Chemicals considered to be maintenance related are kept on-site in the kitchen in a locked supply room or in the housekeeping storage room. All other chemicals are stored in a locked cabinet outside the program property next to the physical plant manager's office and the cabinet is marked as flammable. No youth has access to any type of chemicals. The program director, assistant program director, housekeeping and physical plant manager are the only staff with access to the chemicals. The program maintains inventories of all flammable, poisonous, and toxic items and materials. The program has a central binder with copied pictures of all the chemicals on-site with an attached safety data sheet 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 has a policy and procedures in place for maintaining control of flammable, poisonous, and toxic items and materials. The program has a housekeeper who completes the facility cleaning and maintains the substances used to perform the daily tasks in a locked housekeeping closet. All youth in the program are not permitted to handle flammable, poisonous, and toxic items and materials. During the annual compliance review, observations of youth handling flammable, poisonous, and toxic items and materials was not observed. Seven youth were interviewed, and they indicated they do not use any chemicals or cleaning products.

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

The program has a policy and procedures in place for the disposal of flammable, toxic, caustic, and poisonous items. The program's physical plant manager primarily handles the disposal of flammable, toxic, caustic, and poisonous items. The program stores all flammable and poisonous chemicals in marked locked cabinets outside the facility property next to the physical plant manager office. The program keeps a running inventory of use of chemicals and safety data sheets of each stocked chemical on-site. An informal interview with the assistant program director indicated according to the program's policy all chemicals which need to be disposed of are taken to the Pasco/Hernando County landfill hazardous waste disposal site. A review of the program tracking sheet of disposal noted the last disposal of such chemicals occurred in February 2019. An interview with the program director confirmed all hazardous materials are disposed of at the Pasco/Hernando County landfill.

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

The program has a written policy and procedures to address provision of recreation and leisure activities. There is a posted daily youth program schedule throughout the facility, which reflects allotted timeframes for recreational activities to occur. A review of the program youth schedule indicates the youth are provided daily recreation for at least one hour a day. The program also has a separate youth activity schedule outlining all the different recreational and leisure activities for each day; such as, basketball, soccer, flag football, sit-up and push up challenges. On days when the weather does not allow youth to go outside, large muscle group activities are conducted inside on the youth dormitories. The program activity schedule confirmed the provision of activities based on the developmental level and needs of the youth in the program. The program has an on-site recreational therapist holding the credential of a bachelor's degree in sports and exercise science. The recreational therapist provides recreational activities at

various times during the morning, afternoon, evening and on weekends. An informal interview with the recreational therapist was completed and they indicated meetings with all youth are conducted to develop recreational goals, which are documented on each youth's recreation wellness plan form. Additionally, the recreational therapist meets often with the youth in the program, to discuss implementation of other recreational activities and challenges. Based on a youth's body mass index (BMI) a special exercise routine is provided to the youth who exceed their height and weight BMI, so they can complete additional exercises in their room. A review of seven youth recreation wellness plans confirmed each youth had recreational goals to complete while in the program. The program has a youth advisory board, which allows dormitory leaders to be representatives for other youth in a forum setting with program administration to express suggestions, ideas and feedback on programming improvements and activities.
A review of the facility logbook indicated youth movement to and from recreation was not consistently documented, which indicated to the review team the youth were not consistently receiving their one hour physical and leisure activities. A review of seven randomly selected dates in the logbook indicated there was no recreational activities conducted at the program those days. Further review of the logbooks from March 1, 2019 through April 7, 2019 revealed the youth participated in recreation activities eight out of thirty-eight days. During the debriefing process, the program did not make any rebuttal statements indicating recreation was occurring or not occurring; however, during the annual compliance review the team did observe the youth participating in outdoor recreation.

Seven staff were interviewed, and five staff indicated outdoor recreation occurs, weather permitting. One staff indicated they could not answer if recreation occurs daily because they are on third shift and are not present to observe if it happens. A second staff member indicated recreation does not occur every day and it depends on the supervisor who is on duty; however, it does happen two or three times a week. Seven youth were interviewed about being offered recreation for one hour daily and two of the youth indicated they go outside daily and five indicated they do not. During the interviews three youth indicated they go outside maybe two or three times a week; however, it depends on the staff on duty. One youth indicated recreation time is dependent on the day and if the staff want to go outside. Another youth indicated they have been going outside more lately than they have been in the past. Two interviewed youth indicated they play basketball, and football when they go outside.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures addressing visitation and communication. The program provides youth the opportunity to communicate by telephone and written mail with individuals who are approved by their juvenile probation officer (JPO). All incoming and outgoing mail is screened by program staff to ensure positive communications with correspondents. During a youth's admission and orientation process an approved visitation and telephone call list is created by staff and confirmed with the JPO. The youth is provided a youth handbook for further reference on communication access. The parents/guardians of the youth also are provided a parent handbook outlining the same information. The visitation policy is posted upon entry into the facility. The program's daily youth schedule also indicates the days and timeframes of visitation. The program has a binder with copies of each youth's approved correspondence (phone, mail, and visitation) list and it includes a running monthly log of each youth's communications. The program has scheduled visitation for the youth set for Saturday

and Sunday between the hours of 1:00 p.m. to 4:00 p.m.; the information was verified through documentation and youth interviews. Alternate visitation arrangements are provided as needed and are set up between the youth's parents/guardians and program administration. A review of the visitation sign-in/sign out logs, along with phone logs for the review period confirm youth are given the opportunity to communicate with family members by mail, phone and visitation. The phone logs do not consistently record the youth's level phase which does not allow the staff to be immediately aware of how long each youth's phone calls should be. All logs did document at least ten to fifteen minutes of phone time for each youth. Seven youth were interviewed, and five youth indicated they are provided the opportunity to communicate with family by mail, telephone and written correspondence. The sixth youth indicated they refuse to talk with their father. The seventh youth indicated they were in the custody of the Department of Children and Families.

5.24 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 has not had to place any youth into controlled observation; therefore, there was no documentation to review for compliance.

5.25 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 programs process for placing a youth in controlled observation. Since the last annual compliance review the program has not had to place any youth into controlled observations; therefore, there was no documentation to review for compliance.

5.26 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 has not had to place any youth into controlled observations; therefore, there was no documentation to review for compliance.

Program Name: Columbus Youth Academy
Provider Name: Sequel Youth and Familyl Services, LLC
Location: Hillsborough County / Circuit 13
Review Date(s): April 23-26, 2019

MQI Program Code: 1442
Contract Number: 10476
Number of Beds: 50
Lead Reviewer Code: 140

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.02 Five-Year Rescreening	
2.10 Performance Plan Revisions	
3.13 Suicide Prevention Training*	
5.21 Recreation and Leisure Activities	