STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Central Pasco Girls Academy

TrueCore Behavioral Solutions, LLC
(Contract Provider)
2953 Wilson Road
Land O'Lakes, Florida 34639

Review Date(s): November 5-8, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Amanda Nelson, Office of Program Accountability, Lead Reviewer ([Standard 1)
Melissa Johnson, Office of Program Accountability, Central Region Supervisor (Standard 2)
Angel Perez, Office of Program Accountability, Operations Review Specialist (Standard 4)
Jonathan Thompson, Office of Program Accountability, Regional Monitor (Standard 3)
Carlos Valdes, AMIkids, Executive Director, AMIkids Prevention Tampa (Standard 5)

Program Name: Central Pasco Girls Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Pasco County / Circuit 6
Review Date(s): November 5-8, 2019

MQI Program Code: 1203
Contract Number: R2102
Number of Beds: 32
Lead Reviewer Code: 177

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.01 Initial Background Screening *	1.02 Five-Year Rescreening
5.10 Vehicals and Maintenance	
5.26 Safety Planning Process for Youth	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Central Pasco Girls Academy is a thirty-two bed program, for thirteen to eighteen-year-old females for non-secure commitment, located in Land O' Lakes, Florida. The program is operated by TrueCore Behavioral, LLC., through a contract with the Department. The program provides intensive mental health services. In addition, the program fosters each youth by providing Thinking for a Change (T4C), VOICES, Teen Relationships, Impact of Crime (IOC), Living in Balance (LIB), SAVVY Sisters, and the curriculum – Don't Let Youth Emotion Run Your Life. Additional treatment services provided the program includes family and individual therapy, conflict resolution, stress management, recreation therapy, anger management, impulse control groups, and Healthy Body and Brain Matters. Program administration is comprised of a facility administrator, assistant facility administrator, director of case management, a case manager, and the transition service manager. Mental health staff at the program includes the designated mental health clinician authority (DMHCA), who is a licensed mental health counselor (LMHC), as well as three full-time non-licensed master's-level therapists and the therapeutic activity specialist who is also a master's-level therapist. The program has an agreement with a medical doctor (MD) to serve as the program's psychiatrist to provide services weekly and is on-call for emergency consultation twenty-four hours a day. The program has a contracted psychiatrist who provides psychiatric services and medication management at the program for a minimum of one hour a week. The psychiatrist has an advanced practice registered nurse (APRN) who serves as the backup psychiatrist on an as-needed basis. The program also has an agreement with a psychologist to provide services weekly. Medical services are offered from 7:00 a.m. to 7:30 p.m., seven days a week and are provided by one registered nurse and two full-time licensed practical nurses (LPN) and three pro nata LPNs. The designated health authority is a MD contracted with the program to provide medical services for two hours weekly and provide on-call service twenty-four hours a day for medical emergencies and consultations. Human Immunodeficiency Virus (HIV) counseling and testing services are provided by the Pasco County Health Department. Educational services are provided by the Pasco County School Board. The layout of the program includes one building which houses two dormitories and cafeteria, one building which houses administration, therapist, and case manager offices, two stand-alone buildings which each contain a classroom, a building containing the medical clinic, and master control building. The program has forty-eight cameras and all were operational at the time of the review. At the time of the annual compliance review, the program had nine vacant youth care worker positions.

Strengths and Innovative Approaches

- Youth have attended community outings to the Metropolitan Ministries, Florida Aquarium, the Grand Prix, and a local indoor skating rink. The youth advisory board hosts bake sales to fundraise money for these outings.

- Youth have participated in poetry/writing workshops and have produced two short magazines/books of their life stories.

- The program started a physical fitness group, Girls for Fitness, for youth who want to participate in total body workouts several times a week and Zumba on the weekends.

- Once a week, program mentors host a sewing group for selected youth. Youth learn how to make pillows and small quilts.

Standard 1: Management Accountability

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

The program has a policy and procedures for the completion of initial background screenings for staff, volunteers, mentors, and interns. The program had ten newly hired staff and three contracted staff since the last annual compliance review. There was one volunteer and/or mentor applicable for an initial background screening. Reviewed documentation supported nine newly hired staff, three contracted staff, and one volunteer and/or mentor received background screenings completed by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each individual's date of hire and/or contact with youth or access to confidential information. One staff member's background screening was not completed prior to the date of hire and/or contact with youth or access to confidential information. The staff member's date of hire was June 3, 2019; however, the staff member's background screening was not received as eligible until June 26, 2019. A review of sample records during the annual compliance review confirmed this staff member had contact with youth and youth records prior to being cleared by the BSU/Clearinghouse. There was evidence in all ten employee records indicating the hiring authority reviewed the Central Communications Center (CCC), Staff Verification System (SVS), and the Florida Department of Law Enforcement (FDLE) Automatic Training Management System (ATMS) as part of the pre-employment background screening process. All ten newly hired staff, three contracted staff, and one volunteer and/or mentor were added to the Clearinghouse employment roster. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the BSU on December 10, 2018, meeting the annual requirement. The Pasco County School Board's Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's BSU on January 23, 2019, meeting the annual requirement. Each direct care staff hired after July 1, 2018 is required to complete a pre-employment assessment and receive a passing score. The program had seven direct staff hired after July 1, 2018, requiring a pre-employment assessment. The previously required pre-employment assessment was called the Ergometrics IMPACT for Juvenile Corrections Exam. On September 1, 2019, program changed pre-employment assessment tools from the Ergometrics IMPACT for Juvenile Corrections Exam to the Berke Assessment. Documentation reviewed found a pre-employment assessment was completed by the seven newly hired direct care staff and a copy of the passing score was maintained in each staff's personnel record.

1.02 Five-Year Rescreening	Failed 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 for conducting five-year background rescreenings for all staff, volunteers, and interns in accordance with Department requirements. The program had one staff member applicable for a five-year background rescreening. The contracted staff member did not have a rescreening completed prior to their five-year anniversary date, with the information submitted to the Department's Background Screening Unit at least ten days prior to their anniversary date. The rescreening was submitted to the Department's Background Screening Unit ninety-two days late and was received eligible seventy-nine days late. There were no volunteers, mentors, or interns who were applicable for a five-year rescreening.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *The residential program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center telephone number for youth 18 years of age and older telephone number.* • *All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.* • *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.* • *The environment is free of physical, psychological, and emotional abuse (incorporating trauma responsive principles).* • *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety, while also incorporating trama responsive practices.* • *The program shall complete or schedule a TRACE self-assessment.*	

The program maintains a policy and procedures which outlines an environment free of abuse and neglect in which youth and staff feel safe and secure. Additionally, the program maintains an employee handbook which outlines the program's code of conduct to include trauma responsive practices. All staff are required to electronically sign and acknowledge receipt of the employee handbook and code of conduct which outlines the grievance policies and their understanding of the program's code of conduct. A review of ten personnel records found each

record contained documentation of acknowledgement, receipt, and review of the program's code of conduct. Observations during the facility tour of the physical plant found postings of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) throughout the program. There is a telephone in the cafeteria which allows each youth to have direct access to the Florida Abuse Hotline. If youth are in another area of the program and wish to make an abuse call, staff will bring the youth to the cafeteria to allow the youth to call the Florida Abuse Hotline. If the dedicated phone line is not working, staff will make the call from a supervisor's cellular phone. All allegations of abuse or neglect, as well as CCC reports, are logged and maintained in the program's logbook. Five interviewed youth reported they are aware of the abuse reporting process. Each youth reported never being denied access to contact the Florida Abuse Hotline or the Department's CCC. All five youth reported they always feel safe in the program and have never been denied any basic rights. Two interviewed youth alleged emotional/psychological abuse by the same staff member. One of the two youth requested to make an abuse call, and the assistant facility administrator (AFA) and annual compliance review team helped facilitate. The other youth alleging emotional/psychological abuse did not wish to make an abuse call; therefore, the annual compliance review team and regional compliance manager made an abuse call on behalf of the youth. Both abuse calls were also reported to the CCC and the staff member was removed from the dorm where the youth reside. Three out of five interviewed youth stated they have heard the staff using profanity, though typically not towards youth. Five interviewed staff reported they are required to allow youth to make an abuse call, if requested, and they have never observed another staff member telling a youth they could not make an abuse call. Each interviewed staff was able to describe in detail the program's abuse and CCC reporting process. A review of all incidents since the last annual compliance review found there was one incident which involved substantiated complaints against staff, the staff involved were immediately suspended from youth contact and were terminated or resigned within a month of the abuse call/CCC report being made. A review of the Inspector General's final report regarding this incident confirmed staff were terminated or resigned and no other recommendations were made. There were no incidents which should have been reported and were not. The program completes a yearly TRACE self-assessment and surveys to gauge the level of trauma-informed and caring approach to youth care is provided within the facility. During the annual compliance review, the review team did not observe any physical, emotional, or psychological abuse. Interview with facility administrator stated all staff are mandated reporters and can contact the Abuse Registry at any times. Youth who request to contact the abuse registry are provided with the opportunity to do so. There is a dedicated phone line for youth to directly call the Florida Abuse Hotline at will.

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

The program maintains a policy and procedures which address management's response to allegations. A review of internal incidents and reports made to the Department's Central Communications Center (CCC) found the program had eleven incidents concerning allegations against staff for incidents of physical, psychological, and/or emotional abuse since the last annual compliance review. Reviewed documentation for the five randomly selected incidents reflected management immediately initiated an internal investigation and placed the staff member on administrative leave. Only one incident was substantiated, and the two staff involved were terminated or resigned. Prior to their termination or resignation, program placed

staff on administrative leave pending results of the investigation. During an interview with the facility administrator, it was reported staff are trained on incident reporting as part of their pre-service training and this was confirmed by a review of ten personnel training records and the program's training plan. Any allegations against staff are also reviewed daily during the morning management meeting.

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

The program has a policy and procedures regarding reports to the Department's Central Communications Center (CCC). The program had twenty-one incidents reported to the CCC during the last six months, of which five were reviewed. Documentation validated each incident was reported to the CCC within the mandatory two-hour time frame and in accordance with CCC reporting procedures. The program maintains a master logbook for documenting reports to the CCC and a review of the logbook supported three of the five incidents were documented in the logbook, as required. The remaining two incidents involved staff allegations which was not documented in the logbook due to confidentiality. A review of internal incidents for the past six months determined there were no incidents which should have been reported to the CCC and were not. A comparison of reportable incidents during the same time period last year showed a decrease of the reportable incidents from twenty-two incidents during the same time period last year, to twenty-one incidents this year. The program's facility administrator stated all youth are explained their rights and how to report abuse during their orientation.

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

The program has a policy and procedures, as well as a written plan, addressing the utilization of Protective Action Response (PAR). The program's PAR plan was approved by the Department's Residential Program Director on March 13, 2019. The program had three PAR reports completed within the last six months. Each report reflected documentation showing each report included a review by a PAR-certified instructor and processed within the seventy-two hour required time frame by all required parties. Reviewed documentation showed all three reports documented a post-PAR interview with the youth conducted within thirty minutes of the incident. A review of the PAR incident reports and comments by the facility administrator (FA) or designee within seventy-two hours of the incident, was found in each PAR report. None of the reviewed reports required a PAR medical review. Documentation confirmed each report was processed by a supervisor and a PAR instructor to determine if use of force was consistent with the policy in each PAR report. The PAR incidents did not include the use of mechanical restraints and there were no allegations of abuse made by youth or injuries to youth or staff. The program maintains a PAR binder which contains all PAR reports and PAR monthly summary reports. The program's PAR rate has decreased since the last annual compliance review from 1.77 to 1.35. The program's PAR rate during the annual compliance review period was 1.35,

which is below the statewide residential PAR rate of 1.59. Monthly PAR summaries were submitted to the Department within two weeks of the end of each month. An interview with the FA indicated all PAR incidents are reviewed by FA for appropriateness and then discussed with the program's management team during their daily management meeting. If necessary, youth will receive a special treatment team meeting for their behavior and receive appropriate consequences determined by the management team.

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

The program has a policy and procedures addressing pre-service training. The program maintains a pre-service training plan and calendar for all new staff which was submitted to the Department's Office of Staff Development and Training on March 13, 2019 and approved on April 12, 2019. Pre-service training is provided through a combination of instructor-led and web-based courses, as well as on the job training. Five staff training records were reviewed for pre-service training. All five records reflected staff completed the certification process within 180 days of hire and completed all required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. A review of all five staff training records showed documentation to support each staff exceeded the required 120 hours of pre-service training. All contractual required trainings were completed for all five staff reviewed. Documentation showed all training was delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro).

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

The program maintains an in-service training plan which was submitted to the Department's Office of Staff Development and Training on March 13, 2019 and approved on April 12, 2019. Five applicable staff training records, including three supervisor's training records were reviewed for in-service training. Each reviewed staff training record documented staff exceeded the twenty-four hours of in-service training requirements. Each staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff also completed training in professionalism and ethics, including standards of conduct, as well as suicide prevention. All five staff had the required semi-annual emergency response training, prenatal and neonatal staff education, and training in monitoring, observation, and emergency room care of pregnant females and their infants. Three supervisor training records were reviewed for completion of eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, communications skills, and fiscal. Reviewed documentation supported each supervisor exceeded this requirement. All trainings were delivered by qualified trainers and documented in the Department's Learning System (SkillPro). The program's

contract requires staff receive training in the Prison Rape Elimination Act (PREA) every two years and all five training records reflected staff were trained in PREA. All six licensed nursing staff had the required current certification in CPR with AED.

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 addressing the grievance process. The program maintains a training plan for all pre-service training which includes grievance process and procedures. The program's policy indicates if the youth requests assistance in filling out the grievance form the staff, family, and peers or other advocates can help the youth fill out the form or fill it out for them. A review of ten staff training records showed all staff received the required grievance process and procedures training. The program follows a three-phase grievance process to include informal phase (Chatty Cathy form), formal phase, and appeal phase. Chatty Cathy forms allow youth to voice objections and informally file an issue or complaint prior to filing a formal grievance. Youth request a form from staff if they want to complete and informal or formal grievance. There is a locked box for all Chatty Cathy and formal grievance forms in the cafeteria which youth have access to several times throughout the day. If a youth is not satisfied with the resolution from the informal phase, they may submit a formal grievance form. The transition services manager (TSM) acts as the program's grievance officer. The grievance officer or designee will respond to all informal grievances within thirty-six hours and all formal grievances within seventy-two hours. Any grievances alleging sexual abuse or sexual harassment must be responded to by the facility administrator within forty-eight hours. If the youth is not satisfied with the response from the formal grievance, the youth may appeal the decision. The facility administrator (FA) is responsible for handling all grievance appeals. The FA will conduct a hearing, if necessary, and a written result of the hearing will be provided to all participants within twenty-four hours. During an interview, the FA reflected understanding of the grievance policy and procedures. There was a total of thirty-four grievances filed in the last twelve months, of which five were reviewed. A review of five grievances revealed each grievance was resolved at the formal level and within the required seventy-two-hour time frame. Each grievance documented the youth's participation, supervisory oversight, and final outcomes. Five staff interviews were conducted in which each staff reported knowledge of the grievance process. Five interviewed youth stated they were aware of the grievance process, had access to grievance forms whenever needed, and could request assistance in filling out the grievance forms, if needed.

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

The program provides delinquency interventions utilizing evidence-based practices, promising practices, or practices with demonstrated effectiveness for each youth. Evidenced-based

interventions are those designed to reduce the influence of risk factors related to re-offending behavior. The program utilizes Thinking for a Change (T4C), VOICES, and Impact of Crime (IOC) as the delinquency interventionswith each youth placed in groups according to their identified individual needs. This practice was confirmed by the facility administrator (FA). Interviews with the program's clinical director and FA confirmed delinquency interventions are delivered by the master's-level therapists and designated mental health clinician authority (DMHCA). The FA also advised the youth are matched with their therapists based on each youth's individualized therapeutic needs at a pre-classification meeting prior to admission. A review of each of the designated staff's training records reflected all staff had the appropriate education and qualifications to be hired in their respective positions and completed the required training to facilitate the delinquency intervention groups. Two direct care staff provide fidelity monitoring of intervention groups and have received the required training to do so. The program's daily schedule reflects delinquency intervention and treatment groups are conducted seven days a week, pursuant to the program's contract and a review of sign-in sheets confirmed this practice. Structured, planned programming, and activities are provided for a minimum of sixty percent of the youth's awake hours. A review of five youth individual performance plans supported each youth had at least one delinquency intervention goal addressing an identified priority need. A review of group sign-in sheets validated each youth was participating in an intervention group. An IOC cohort just finished the week prior to the annual compliance review and a T4C cohort would be beginning the next week after the annual compliance review. A VOICES group was observed during the annual compliance review which validated the group was delivered, as designed. All five interviewed youth stated they participated in all groups including IOC, VOICES, T4C, grief group, and body image.

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

The program has a policy and procedures which provides interventions and instruction focusing on developing life and social skill competencies to youth through classroom and group instruction and hands-on experiences, as well as role-modeled by staff and program administrators. Youth receive life and social skill intervention services specifically addressing at minimum: communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking to include problem-solving and decision-making. The program provides groups and curricula including Thinking for a Change(T4C), anger management, SAVVY Sisters, Living in Balance, Don't Let Your Emotions Run Your Life, stress management, conflict resolution, impulse groups, and teen relationships. Each youth is taught employability skills during leisure time by the case management staff or transition manager. Youth are taught how to generate a résumé, complete a cover letter, fill out applications, and interviewing strategies. A review of the program's contract indicates the program has staff trained to provide all of their required life skills and intervention groups, as well as their mental health and substance abuse groups. A review of group sign-in sheets confirmed the program is providing all contractually required groups to youth according to the activity schedule. A review of five youth case management records showed all youth are participating in life and social skills groups and training as required. Interviews with the facility administrator (FA) and clinical director indicated youth attend delinquency and life skills groups daily and are provided an opportunity to practice these skills during their daily routine. Interviews with five youth indicated they are all currently participating in groups to include T4C, VOICES, and grief and loss group. Youth interviews also indicated the youth learn active listening skills,

coping skills, and utilize role playing to model desired skills. All five interviewed youth indicated they have been able to use the skills they have learned in their daily routine.

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

The program provides delinquency interventions through evidence-based principles and practices of restorative justice. The evidenced-based interventions are those designed to reduce the influence of risk factors related to re-offending behavior. The program provides the Impact of Crime (IOC) twice a week in the evenings, in addition to community service projects which helps to increase awareness and empathy for crime victims and survivors. Youth have made bracelets for at-risk young children, made birthday cards for the terminally ill, and recently cleaned and helped landscape a foster group home where one of the youth had previously been expelled from for violent behavior on staff years earlier. A review of staff training records showed three staff are trained to facilitate IOC. A review of five case management records showed all five youth had completed the IOC cohort last week. An informal interview was conducted with the designated mental health clinician authority (DMHCA) who most recently facilitated the IOC group to determine how youth are exposed to victim's perspective through victim speakers. The DMHCA stated youth watch a video of six to eight victim speakers during the course of the IOC group. Additionally, a mentor recently spoke to the youth about her experience of her husband being murdered by a juvenile offender. Youth have also watched a YouTube video about the effects on a family who was critically injured by a drunk juvenile driver. The annual compliance review team was unable to observe a restorative justice group, as the last cohort ended the week prior to the annual compliance review and the next cohort does not begin until the following week after the annual compliance review.

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

The program has a policy and procedures which address gender-specific programming for a female population, pursuant to the contract. The program utilizes VOICES as the main gender-specific programming and their program-specific Girls 4 Success model to meet the needs of the program's female population. The program utilizes the Girls 4 Success Model, which identifies signature strengths such as volunteer and family focused services in addition to therapeutic support, health and wellness, academic, and life skills services. The program also utilizes the SAVVY Sisters group which focuses on needs specific to the female population served by the program. Interviews with the facility administrator (FA) and clinical director indicated all treatment planning is individualized and focuses on the gender-specific therapeutic needs of each youth, which was also confirmed by group sign-in sheets and the five youth interviews conducted during the annual review.

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

The program has a policy and procedures regarding entering alerts into the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. During an interview with the program's facility administrator, it was confirmed the JJIS alert reports and internal alerts are distributed and reviewed daily by administration during the morning management meeting and each department head is responsible for managing alerts applicable to their department. There is an internal communication board in the staff breakroom which displays current, open, applicable alerts and is updated as-needed. Supervisors also discuss the alerts with all working direct-care staff at each shift briefing. A review of five youth records found each youth was applicable for having an alert entered into the program's internal alert system and the JJIS alert system. Reviewed documentation supported each youth had the appropriate alert entered into the internal alert system and each was entered into the JJIS alert system. All applicable youth were removed or downgraded from alert status by appropriate staff in a timely manner. Three out of five youth records were applicable for documentation of alerts in the logbook and all three youth's alerts were found in the logbook. The facility administrator (FA) confirmed only medical staff are allowed to remove or downgrade a medical alert and only mental health staff are allowed to remove or downgrade a mental health alert. All five staff confirmed they are informed of medical and mental health alerts by the internal alert board. One staff member indicated they worked in case management and also receives alerts from the electronic commitment packet (ECP) and emails about mental health and medical alerts.

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

The program maintains a policy and procedures relating to the maintenance, creation, and storage of individual healthcare, mental health, substance abuse, and case management records for each youth. The program maintains individual, color-coded, hardbound binders for case management, healthcare, and mental health and substance abuse records. Observations of the records found each labeled "confidential" and secured in file cabinets identified as "confidential" in assigned locked offices inaccessible to youth. Observations of the records showed each youth record had the required documentation on the spine and the front of the binder, to include the youth's name, date of birth, county of residence, date of admission, committing offense, and Department identification number (DJJID). Reviewed records showed all the required recent information in chronological order. Documents were organized into

required sections and information was separated into designated sections with tabs for legal, demographic, case management with treatment plan and interventions, and correspondence along with a miscellaneous tab.

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

The program has a process to promote constructive input from youth. The program maintains a youth advisory board comprised of youth enrolled in the program, giving youth the opportunity to have verbal contact with the program's administration regarding program operational issues, complaints, and/or suggestions. All youth who participate on the youth advisory board must apply, maintain a C grade average, be in one of the last two phases of the program, and maintain good behavior. Additionally, the program utilizes "Chatty Cathy" forms, daily meetings, a youth suggestion box, and monthly community meetings which gives each youth an opportunity to address both positive and negative issues they may have. The youth advisory board meets monthly with administration. Reviewed documentation revealed meetings were held six times during the past six-month period. Each meeting followed an individual agenda which addressed each request or complaint accordingly, either during the following month's youth advisory meeting or with program leadership. Some topics discussed during the youth advisory board meetings included incentive calendar ideas, requests for supplies for recreation, inappropriate behavior during social activities, and an upcoming spirit week. Five interviewed youth stated they could provide feedback and input if desired. All five interviewed youth reported being able to participate in student advisory boards, Chatty Cathys, youth surveys, and daily meetings as a way of providing input to the program. During an informal interview with the facility administrator (FA), it was revealed the program receives input from the youth regarding programming from the youth advisory board and the youth suggestion box.

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

The program maintains a policy and procedures for maintaining an advisory board.
The program maintains a list of community advisory board members from the school board, law enforcement officials, community partners, faith-based organizations, a local mentoring agency, judiciary, business community, victim advocates, and parents/guardians of former/present residents. Reviewed documentation reflected the program's community advisory board met on November 7, 2018, March 29, 2019, June 19, 2019, and September 30, 2019. There was clear documentation to support the program made attempts to schedule meeting dates, working around community advisory board member's schedules, by the program's facility administrator mailing a letter in advance of the scheduled meeting to increase attendance. Attempts were made for recruitment efforts from law enforcement, the judiciary community, other community partners, business community, school board, faith community, victim advocates, and parent/guardians. Reviewed community advisory board agendas and meeting minutes documented the program provides the board members with information regarding program updates, community updates, and giving back to the community. During an informal interview with an advisory board member, it was stated meetings are held quarterly and the program is very receptive to board member's feedback. An interview with facility administrator revealed the role of advisory board is to provide resources and support to the program. One example of this,

was advisory board members helping the program build connections with community partners to aid the youth with participating in community service projects.

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, monthly supervisor meetings, and daily management meetings to share information with staff and to enhance program planning. A review of the program's meeting binders indicated meetings were held monthly or daily and were held accordingly during the annual compliance review period. A review of the all staff meeting minutes indicated the program reviews with staff the quality improvement reports, red flag issues, medical updates, mental health updates, drill reviews, human resources issues, policy reviews, and safety and security issues. A review of the daily management meetings indicated the management team discussed programming issues, grievances, Central Communications Center reports, incident reports, youth issues, education issues, Protective Action Response (PAR) incidents, program trends, alert trackers, sick calls, and staff vacancies. Monthly staff meeting documentation reflected a review of the annual compliance report and the Comprehensive Accountability Report (CAR). The program also conducts parent/guardian surveys upon each youth's admission and discharge from the program, and a random sample of half of all youth and parent/guardian surveys on a quarterly basis. The feedback received from the surveys is discussed with administration and used to enhance programming. The program has a policy and procedures in place for employment recognition. TrueCore programs are recognized with additional monetary gifts for meetings program goals which are utilized to facilitate staff parties and boost morale. The program also received a contract amendment this year to provide monetary bonuses to staff to encourage retention. The program also utilizes a program called the TrueCore Way for staff members going above and beyond, which allows supervisory staff or clients to recognize staff for exemplifying the TrueCore way. Program also has an employee morale committee which organizes morale boosting activities such as jeans day and spirit week. During an interview with the facility administrator (FA) and regional compliance manager, it was confirmed the program holds monthly staff meetings, monthly supervisor meetings, and daily management meetings to keep staff informed of events going on in the program. The FA stated the program has implemented jeans Friday to boost staff morale. The regional compliance manager also established youth and parent/guardian surveys are conducted quarterly and the information collected is shared with staff and used to improve programming. Five interviewed staff members confirmed the program holds monthly staff meetings. One out of five staff interviewed also stated supervisor meetings are held weekly, or on as-needed basis. The five interviewed staff indicated youth behavioral issues, youth alerts, program trends, drills, and department-related topics are discussed during monthly staff meetings. Four out of five staff indicated they are briefed on annual reports. Three out of five staff stated they were not briefed on survey results. All five interviewed staff indicated communication at the program is very good, good, or fair. All staff indicated the administration has an open-door policy and they can communicate any concerns with the administration.

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

The program has a policy and procedures addressing the evaluation of staff performance. Performance evaluations are completed within ninety days of hire and then annually thereafter,

for all staff by department heads. During an interview with the facility administrator (FA), it was found annual evaluations are completed to provide feedback to staff regarding their performance over the prior year to include implementation of the positive performance system (PPS) and their overall specific job duties. Goals are also identified for the upcoming year. Each staff is also given the opportunity to provide comments and written input during this time. Performance evaluations address performance standards to include job duties, job knowledge and competency, teamwork, professionalism, and goals achieved. Evaluations are explicit to different categories of staff positions. Staff can be rated as commendable, acceptable, needs improvement, unacceptable, or non-applicable. Each performance evaluation provides an overall numerical rating at the end of the evaluation. Five staff were interviewed about performance evaluations. One staff indicated they receive annual performance evaluations and four staff indicated performance evaluations are completed every six months. Five personnel records were reviewed in which two were supervisory records. Each included the specific job description and applicable performance evaluation. All key positions were filled at the time of the annual compliance review.

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

The program's activity schedule was reviewed along with the program's policy and procedures regarding recreation and leisure activities. The program has a range of supervised and structured indoor and outdoor recreation activities available to youth. Activities include basketball, volleyball, dance, fast walking, arts and crafts, playing cards, making jewelry, and reading. The program currently has one therapeutic activity specialist in accordance with the contract. The therapeutic activity specialist is a master's-level mental health therapist with electives in collegiate sports and experience coaching gymnastics. Five interviewed youth indicated they are provided a variety of activities with varying degrees of mental and physical exertion throughout the day. Five interviewed youth and five interviewed staff indicated youth are provided with at least one hour of large muscle activity each day. During an interview with the designated mental health clinician authority (DMHCA), it was indicated the recreation activities promote community wellness which allows youth to contribute to the group culture, promotes social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. A review of the logbook reflected a minimum of an hour of recreation activity is provided daily for all youth. Five youth records were reviewed and all youth have wellness goals on their treatment plans and updates on the progress of those plans are provided to the treatment team monthly. Youth are provided an opportunity to provide input into the rules and operation of the program through the youth advisory board and youth suggestion box. Five interviewed youth indicated that they receive an hour of recreation and leisure time daily.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures addressing initial contacts to the youth's parent/guardian and court. The procedures require each youth's parent/guardian to be notified by telephone within twenty-four hours of admission, as well as maintain written correspondence within forty-hours of admission. All five reviewed youth case management records contained documentation to support each parent/guardian was contacted by telephone on the youth's admission date. The parents/guardians were also notified in writing within forty-eight hours of the youth's admission. The review of the records also supported the program provided written notification to the committing court and assigned juvenile probation officer (JPO) within forty-eight hours of the youth's admission. Post-residential services were not applicable for any of the youth at the time of admission.

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

The program has a policy and procedures addressing youth orientation. The procedures require each youth to successfully complete a program orientation within twenty-four hours of admission. All five reviewed youth case management records contained documentation to support each youth received an orientation to the program on the youth's day of admission. All five records contained an orientation checklist which addressed all required topics included in Florida Administrative Code. The orientation checklists were signed by the youth and staff completing the orientation. There were no new admissions to the program the week of the annual compliance review. All five interviewed youth confirmed receipt of orientation within twenty-four hours of admission. Orientation included program rules, procedures, schedules, and services offered in the program.

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

The program has a policy and procedures addressing consent of any youth eighteen years of age or older prior to discussing or providing the parent/guardian any information related to the youth's physical or mental health screenings or assessments. Two of the five reviewed case management records were applicable for this indicator; therefore, an additional youth record was provided for review. All three records contained a consent form signed by each youth prior to any release of information.

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

The program has a policy and procedures addressing the classification system. The program's classification process includes each program area reviewing supporting documentation and sharing the information with treatment team during the admission classification meeting. Information included in the classification process includes the youth's maturity level, age, history of violence, security alerts, mental health and substance abuse history, medical records, and vulnerability to victimization. A review of five youth records found the Vulnerability to Sexual Aggressive Behavior (VSAB) assessment was completed prior to the classification of each youth. Each VSAB assessment was maintained in the Department's Juvenile Justice Information System (JJIS). Documentation in all five records supported the initial classification information was used for the purposes of assigning each newly admitted youth to a living unit and sleeping room. The program has a process in place to reassess and reclassify youth prior to considering an increase in privileges, participation in work projects of other activities involving tools. A risk reassessment was completed for all five youth monthly. The risk reassessments documented what privileges the youth could participate in or if the youth was a safety or security risk. Risk reassessments were completed appropriately for youth who were permitted to participate in off-campus activities. Four interviewed youth indicated they used Class B tools and one youth indicated they used a power washer. Three of the five youth had risk re-assessments completed during treatment team meetings indicating the youth were permitted to use class B tools. The one youth who indicated they used mops and brooms a month ago was not approved to use class B tools on the risk assessment. The youth who indicated she used a power washer was not approved to use class B tools on the risk assessment. During the interview with the facility administrator, the classification process was explained. The facility administrator indicated the youth's living placement is based on alerts identified during the VSAB and admission classification. Based on those alerts, youth will be best placed in their sleeping quarters.

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

The program has a policy and procedures to address gathering information on gangs and sharing this information with law enforcement. Two of the five reviewed case management records were applicable for this indicator; therefore, an additional youth record was provided for review. All three applicable youth records confirmed notification to law enforcement was made to the Pasco County Sherriff Department and the youth's community law enforcement agency. Documentation supported the educational staff and the youth's assigned juvenile probation officer (JPO) were also notified. All notification was made by the case manager the day the

youth was identified with gang affiliation. The Department's Juvenile Justice Information System (JJIS) reflected all gang alerts were entered upon identification.

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 addressing the gang prevention and intervention services offered to youth identified as being a member of or affiliated with a street gang. Two of the five reviewed case management records were applicable for this indicator; therefore, an additional youth record was provided for review. All three applicable youth's Individual Performance Plans included a gang intervention. Documentation supported all three youth worked individually with their case manager and completed assignments from the GANGS – 50+ Stories of Fractured Lives curriculum. These meetings took place on a monthly basis with the youth's case manager.

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

The program has a policy and procedures ensuring Residential Assessments for Youth (RAY) assessments are to be completed within thirty days of a youth's admission. All five reviewed youth case management records contained a RAY assessment completed within thirty days of the youth's admission. All five youth were also applicable for RAY re-assessments. Four of the five youth received RAY re-assessments, which were completed within ninety days after the completion of the initial RAY. The remaining youth's re-assessment was completed one day late. All initial RAY assessments and re-assessments were completed in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures to ensure a Youth Needs Assessment Summary (YNAS) is completed within thirty days of a youth's admission. All five reviewed youth case management records contained a copy of the YNAS which were completed within the required time frame. All five assessment summaries were maintained in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures to ensure the treatment team develops the youth's Individual Performance Plan (IPP) within thirty days of a youth's admission. All five reviewed youth case management records contained an IPP developed within the first thirty days of each youth's admission. The IPPs included input from all members of the youth's treatment team and included individualized goals based upon the prioritized needs identified during the initial assessment process. All five plans included delinquency interventions, measurable goals, and outlined the staff and youth responsibilities to accomplish the goals. One youth was applicable for targeted court-ordered sanctions, which were addressed in the youth's IPP. All five records contained documentation to support copies of the IPP were sent to the committing courts, assigned juvenile probation officers (JPO), and parents/guardians. Five youth were asked to explain the program's treatment process including development of the performance plan, treatment team meetings and goals. All five interviewed youth indicated they, along with their case manager developed their performance plan goals. The youth indicated they meet monthly for treatment team and discuss the goals they are working towards. One youth indicated each month they meet for treatment team and new goals are assigned for the completion prior to the next formal treatment team. The youth also stated treatment team needs to approve the youth to apply to move to the next level in the program.

2.10 Performance Plan Revisions	Satisfactory Compliance
Performance reviews shall result in revisions to the youth's performance plan when determined necessary by the intervention and treatment team.	

The program has a policy and procedures to address revisions of the youth's performance plan when determined necessary by the treatment team. All five reviewed youth case management records contained Individual Performance Plans (IPP) revised on a monthly basis during treatment team meetings. Revisions were made based on the Residential Assessment for Youth (RAY) re-assessments and completion of goals. There were examples of target dates revised based on the youth's lack of progress on accomplishing goals when applicable. Three closed records contained IPPs revised due to information discussed during the transition conference and goals developed which had a targeted date for completion during the last sixty days of the youth's stay in the program.

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

All five open youth case management records and three closed youth records contained a performance summary completed every ninety days during the youth's stay in the program. All summaries included information on the youth's status on the performance plan goals, overall treatment progress, academic status including performance and behavior in school, the youth's overall behavior including the youth's current level for change, and any significant positive or negative events. The performance summaries in the closed records also included the justification for the request for release. Summaries included reports on education, mental health, performance plan goals progress, staff and peer interactions, the youth's level of motivation to change, significant events and anti and pro-social behaviors. One of the five records contained a release summary which was sent to the committing court within the required time frame. Two additional close records were reviewed for release summaries, and each summary contained a justification for discharge from the program. Documentation supported the youth were provided an opportunity to make a comment on the completed summaries. All summaries were signed by the youth but not all youth made a comment or documented they did not have a comment. The performance summaries were also signed by the required treatment team members. All reviewed records contained letters to support performance summaries were sent to the youth's committing court, juvenile probation officer (JPO), and parent/guardian. One youth was involved with the Department of Children and Families (DCF) and those applicable performance summaries were mailed to the DCF representative. The original summaries were located in the youth's record. Three of the five interviewed youth indicated they received a copy of their performance summaries. One youth indicated they did not receive a copy of the summary and the other youth was not applicable for receiving a summary. The director of case management indicated they keep the copies of the youth's performance summaries in individual folders and provide the copies when the youth are released from the program. The program does not want the youth to take copies of their performance summaries back to the dorms in fear other youth will obtain the information.

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.	

All five open youth case management records and three closed youth records contained documentation to support the parent/guardian was included in the assessment process, performance plan development, progress reviews, and transitional planning. Each record contained documentation case management staff made contact with or attempted to contact the youth's parent/guardian during monthly formal treatment team meetings. Five youth case management records were reviewed, and each contained documentation the parent/guardian participated in the creation of the Individual Performance Plan, treatment team meetings, and

monitoring events. Each record indicated multiple attempts of notification to the parent/guardian to participate in treatment services and treatment team meetings, which included mailing a schedule of youth events, telephonic encouragement to participate in activities, telephone meetings, as well as being mailed copies of youth documentation. An interview with the facility administrator (FA) indicated parents/guardians are notified of and invited to all scheduled meetings involving their youth from the date of admission until the time of discharge. Four of the five interviewed youth indicated their parents/guardians are involved in their case management activities. One youth has no contact with their family. The program is assisting the youth in establishing services with the Department and Children and Families (DCF). During the interview with the facility administrator, the process of encouraging parental involvement was explained. The parents/guardians are included in the admission process, admission classification, youth needs assessment and monthly youth treatment team meetings either is person or through telephone calls. Youth are also provided a weekly telephone call to their parents.

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

A review of five youth case management records confirmed the multidisciplinary intervention and treatment team consisted of a representative from each area of the program. Formal treatment team meetings were conducted for each youth on a monthly basis. The following participants signed each formal treatment team form: youth, director of case management, director of mental health, living unit representative, therapist, case manager, nurse, education, and the transition services manager. There was consistent documentation to support treatment team made contact with or attempted to make telephone contact with the youth's parent/guardian and juvenile probation officer (JPO). The program had two youth applicable for Department of Children's and Family (DCF) involvement. Both youth case management records documented invitations to the DCF representatives to participate in the meetings. Observations of three treatment team meetings during the annual compliance review revealed active participation by all required staff and parties. Parents/guardians participated in the three observed treatment team meetings through conference call. The assigned JPO participated by telephone in two meetings. The program attempted to contact the third JPO.

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 requiring additional treatment plan information be referenced and/or incorporated in the youth's individualized performance plan. Two records found the plans addressed education but did not address the youth's mental health plans. Three records found the plans addressed both educational and mental health services. The two youth involved with the Department of Children's and Families were not applicable for a specific DCF plan. The program had no applicable youth for involvement with the Agency for Persons with Disabilities.

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

The program has a policy and procedures addressing formal and informal treatment team meetings. The procedures indicate the case manager meets informally with each youth at least biweekly and formal treatment team meetings occur at least once every thirty days. A review of five youth case management records confirmed each youth received formal treatment team reviews every thirty days. All treatment team members signed each formal treatment team meeting form. Progress or lack of progress on the action steps included in the youth's individual performance plan were addressed and updated as needed. Comments from treatment team members were included on the formal treatment team form. The Residential Assessment for Youth (RAY) and RAY Reassessments were reviewed during formal treatment team meetings. Based on the information from the RAY assessments, revisions to the individual treatment and/or performance plans were made, when necessary. Observations of three formal treatment team meetings during the annual compliance review supported the youth's performance plan goals were discussed. All treatment team members were present for the formal meetings.

All five youth case management records contained completed informal treatment team documentation completed once a month. Information reviewed during informal treatment team meetings included the youth's progress in mental health, education, behavior, and performance plan goals. The informal treatment team meeting forms were signed by the youth and the case manager. All formal and informal treatment team documentation included the youth's name, date of review, meeting participants, and an overview of the youth's progression over the last month. Anticipated release dates were appropriately documented in the Department's Juvenile Justice Information System (JJIS). All five interviewed youth said staff reviews progress on performance plan goals, positive and negative behavior, and treatment progress during treatment team meetings. All five youth indicated they are given the opportunity to act out, roleplay, and demonstrate certain skills they are learning and working towards in the program during meetings.

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

The program provides Type 2 career education programming provided by the Pasco County School Board. The career education provided to the students included communication, interpersonal, and decision-making skills appropriate for youth in all age groups and ability levels and are geared to help youth maintain employment. An interview with the lead teacher confirmed various assessments are completed by each youth to include the Armed Services Vocational Aptitude Battery (ASVAB), Learning Styles Inventory, and the Kuder curriculum. These assessments are used to provide youth the opportunity to explore and gain knowledge of occupational opportunities. The lead teacher indicated the youth complete a resume and mock job applications in order for the youth to have the information needed when the youth are out in the community completing real applications. The lead teacher also indicated the career education services included talking to the youth about the career the youth may be most interested in and exploring the career to learn about all the individual job opportunities available

within that particular career. Peer counseling and life skills classes are also offered as a part of the career education curriculum. An interview with the facility administrator supported youth can gain vocational certification in food handling (Safe Staff) and in manager level food service (ServeSafe). All three reviewed closed youth case management records had a completed employment application, résumé, a calendar identifying an appointment with Career Source Center, appropriate documents for obtaining employment, and documentation to support the youth's parent/guardian and juvenile probation officer were made aware of the youth's vocational plan. The facility administrator indicated youth are provided with the opportunity to complete job applications, obtain a state identification card, and complete job applications online prior to release. Youth are provided with the opportunity to participate and earn a ServeSafe Certification.

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.	

Educational services are provided on a year-round basis under the direction of the Pasco County School Board. The daily activity schedule allows for the youth to participate in educational and vocational career-related instruction for, a minimum of 250 days during the calendar year, with a minimum of twenty-five hours of instruction weekly. Ten days are set aside for teacher planning and professional development. A review of the program's daily schedule and logbooks for the last six months reflected youth were provided and/or attended educational classes, as required. The lead teacher reported the youth use the APEX digital curriculum computer program to complete individual and applicable assignments to assist the youth in earning school credits. Two youth are currently taking college classes through the internet because they have earned their General Equivalency Diploma (GED). The lead teacher also reported the teachers offer the youth additional hours for tutoring from 3:00 p.m. to 5:00 p.m. every Tuesday and one Saturday a month. The teachers also attend the program's Family Days to have an opportunity to meet the youth's families and to gain additional perspective about each youth. Three of the five interviewed youth indicated there are not a lot of interruptions during educational instruction hours. One youth indicated the youth will sometimes go to school late because breakfast is late, or the program does not have enough staff to take them to school, or it is raining really hard, so the youth don't go to school. One youth indicated a few times the youth were late because there was not enough staff to take all the youth to school at the same time. The program took half the youth to school for one period and then took the other half of the youth to school for the next period. The fifth youth indicated one period of school was missed recently because there wasn't enough staff to take the youth to school.

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

The lead teacher reported the school counselor reviews each youth's student records and exceptional student education (ESE) status upon arrival to the program to determine the youth's current educational and transition needs. As the youth progresses through the program, the education transition specialist becomes involved with the youth approximately sixty days prior to the youth completing the program. The Electronic Education Exit Plan EEEP is started at the transition meeting. The transition specialist assists the youth in completing any outstanding

resume's and job applications. The transition specialist participates in the Community Re-Entry Team (CRT) meetings. Three closed case management records were reviewed for educational transition planning. All three records contained a detailed education transition plan which was completed prior to the youth's release from the program. Documentation supported all required parties assisted in the completion of the youth's transition plan to include the youth, the youth's parent/guardian, educational staff with access to the district's management information system, certified school counselor, and post-release/re-entry staff. All three plans addressed the youth's individual post-release goals identified at the youth's admission to the program. All three plans identified the individuals specifically responsible for monitoring the reintegration and coordination of support services. All three closed records addressed employability as a transition goal and each plan included provisions for continuation of education or employment. All three closed records contained documentation to support treatment team members including the youth and the youth's parent/guardian were aware of the post-release discharge plan.

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

A review of three closed youth case management records confirmed the program held a transition conference at least sixty-days prior to each youth's anticipated release date. Written notification of the scheduled meeting was sent to all required participants including the parent/guardian, the youth's juvenile probation officer (JPO), educational staff, and other pertinent parties. Reviewed documentation supported the program's treatment team leader, facility administrator/designee, and other treatment team members participated in each transition conference. The parent/guardian and JPO participated in the transition conference either in person or by telephone. Documentation supported transition activities were reviewed during the transition conference, including target dates for goal completion, along with any additional goals needed upon release. Documentation also supported goals for completion of transition activities were identified during the transition conference. One of the three youth had a revised transition plan completed after the youth's original release date was denied by the committing judge. The second transition plan completed contained the original target completion dates as the original plan. Copies of the complete transition plan were sent to the youth's parent/guardian and juvenile probation officer (JPO). All three closed youth case management records contained evidence an invitation to participate in the Community Re-Entry Team (CRT) meeting was distributed to all applicable parties. Completed documentation supported each youth, case manager, and education staff participated in the CRT meetings.

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.	

A review of three closed youth case management records confirmed an exit portfolio was completed by the program and the youth. Documentation supported the youth's exit portfolio was discussed and initiated for the youth during the transition conference. Each record contained a copy of the youth's birth certificate, social security card, and State of Florida identification card or documentation to support the attempts to obtain these documents. All three records contained a résumé, sample job applications, education records, and a calendar with dates, times, and locations of follow-up appointments within the community. Reviewed documentation supported the youth's exit portfolio was verified at the youth's exit conference and sent to the youth's juvenile probation officer (JPO). Documentation supported the completed exit portfolio was provided to the youth upon their release.

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

The review of three closed youth case management records supported the exit conference was conducted after the program notified the juvenile probation officer (JPO), youth's parent/guardian, education representative, and other pertinent parties of the meeting. All three exit conferences were held within fourteen days prior to the youth's release. Reviewed documentation supported each exit conference was documented in the case record to include dated signatures of all applicable participants. When applicable, program staff noted the participants attending the meeting through conference call on the signature line. Reviewed documentation supported participation of the case manager, parent/guardian, education staff, JPO, youth, and other applicable parties in the exit conference. Each date of admission and release corroborated the dates entered into the Department's Juvenile Justice Information System. The exit conference was separate from the Community-Re-Entry Team (CRT) meeting.

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 maintains a policy and procedures ensuring the provision of mental health/substance abuse services to the youth. The program utilizes a licensed mental health counselor (LMHC) to fulfill the designated mental health clinician authority (DMHCA) position at the program. The DMHCA holds a clear and active license with the Florida Department of Health which expires on March 31, 2021. The DMHCA is responsible for the coordination and implementation of mental health (MH) and substance abuse services at the program. A review of the DMHCA's position description, interviews with program therapists, program leadership, and youth confirmed the DMHCA serves as the focal point for all coordination of MH services including intensive MH treatment services to the youth. The DMHCA is on-site a minimum of five days, for forty hours a week, and is on call twenty-four hours a day, seven days a week, to provide emergency services. An interview with the DMHCA confirmed their role as the coordinator for the implementation of mental health and substance abuse services in the program. The DMHCA also provides weekly face-to-face supervision for at least one hour to master's-level therapists.

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 maintains a policy and procedures ensuring a there is a licensed clinician on staff and the provision of mental health/substance abuse services to the youth. The licensed clinician on staff serves as the clinical director and as the designated mental health clinician authority (DMHCA). The program's provider also employs a licensed mental health clinician (LMHC) as the regional clinical director, to assist the program in meeting the mental health needs of the youth, and to serve as a back-up to the DMHCA. The regional clinical director's license expires March 31, 2021. The program contracts with a psychiatrist and a psychiatric advanced practice registered nurse (APRN), who are on-site weekly to provide psychiatric services to applicable youth. The psychiatrist's license expires January 31, 2021, and the psychiatric APRN's license expires July 31, 2020. All licensed staff are currently licensed in the State of Florida with no restrictions. Reviewed documentation confirmed the psychiatrist and the backup APRN are on-site weekly to provide psychiatric services to applicable youth.

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 utilizes four full-time, non-licensed therapists in providing mental health/substance abuse services to the youth under the program's Chapter 397 license. A review of personnel records confirmed all staff have a master's degree in a required field of study. One of the four therapists is a registered mental health counseling intern. A review of each therapist's training records confirmed all members completion of pre-service training combined with twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Additionally, all non-licensed clinicians completed five Assessments of Suicide Risk (ASR) as part of their training. A review of clinical supervision logs confirmed the designated mental health clinician authority (DMHCA) completed weekly clinical supervision which included one hour of face-to-face direct supervision and case reviews. The DMHCA or a licensed designee conducted clinical supervision for each non-licensed therapist which was completed on-site in a group setting. Clinical supervision session documentation confirmed case consultation, instructions, and recommendations, and a sample of each therapist's work were reviewed during each clinical supervision session. The program utilizes a form for documentation of weekly clinical supervision session which contains all elements on the Department's Mental Health and Substance Abuse (MHSA 019) form for documentation of weekly supervision.

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

The program has a policy and procedures to address the screening of mental health and substance abuse needs of youth admitted into the program. The policy dictates the administration of Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) to screen youth upon admission. The MAYSI-2 is also to be utilized for any youth readmitted into the program custody. Additionally, the program policy dictates each youth is to be issued the MAYSI-2, Assessment of Suicide Risk (ASR), and Victimization and Sexually Aggressive Behavior (VSAB) screenings to gain a comprehensive picture for each youth upon admission into the program. Five mental health and substance abuse records were reviewed and all five contained a completed MAYSI-2 which was administered on the day of admission to the program. A review of staff credentials confirmed all staff administering the MAYSI-2 tool have completed the necessary training. All five records had completed MAYSI-2 assessments and all five resulted in youth being referred for further evaluation and were referred for an ASR and comprehensive assessment. Each youth also received the VSAB and ASR on the day of admission which is accordance with the program's policy. The program utilizes these three tools in creating an individualized comprehensive assessment for each youth and in all five records all actions were completed and filed appropriately. The program has a standing policy which dictates all youth are referred for a psychiatric evaluation and are to be assessed within fourteen days of admission and in all five records reviewed, referrals were entered correctly.

Documentation confirmed each youth's commitment package was reviewed by the designated mental health clinician authority (DMHCA) for each youth upon admission. The facility administrator interview confirmed MAYSI-2 assessments are completed confidentially and all youth admitted to the program will receive an ASR, VSAB, a comprehensive assessment, and an initial evaluation by the psychiatrist.

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 maintains a plan and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan for the delivery of mental health and substance abuse services for the youth includes the admission of a variety of assessments, youth file review, tailoring of an initial treatment plan, and the issuing of a referral for each youth to revive a comprehensive evaluation to be completed within thirty days of admission. The comprehensive evaluation includes elements addressing mental health and substance abuse. The comprehensive evaluation includes relevant background information, such as home environment, family functioning, history of abuse to include physical and sexual, history of neglect, witnessing of violence and other forms of trauma, behavioral functioning, physical health, and educational functioning. Five mental health and substance abuse records were reviewed. All five records contained a referral for a new comprehensive evaluation on the day of admission. All five comprehensive assessments were completed within thirty days of admission to the program, each record required a new evaluation. All comprehensive assessments were completed or reviewed by a licensed mental health clinician. The five assessments contained all information required by the program's policy. Each Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) was completed in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures which regulate the provision of mental health and substance abuse services and includes coordination of mental health and substance abuse services for all youth. According to the policy, upon entry, the program assigns each youth to a multidisciplinary treatment team upon admission to the program. The treatment team consists of the youth and representatives from program administration, the residential living unit, medical, vocational training staff, education, mental health, substance abuse, other staff responsible for delinquency intervention and treatment services, and, when possible, the youth's parent/guardian. Five youth mental health and substance abuse records were reviewed, and each youth record reflected the appointment to a multidisciplinary treatment team upon admission, which consisted of the parties listed above. Each record contained a properly

executed Authority for Evaluation and Treatment form, a signed substance abuse consent forms (MHSA 012), and a 'Release of Information' form. The mental health treatment was documented on forms containing all the information required in the Department's Counseling and Therapy Progress Note form (MHSA 018) in all five reviewed records.

The program is certified by the Department of Children and Families (DCF) to provide outpatient substance abuse treatment services for adolescents under Florida Statute, Chapter 397. In all instances, treatment services including mental health and substance abuse treatment, were provided by qualified licensed clinician or a non-licensed clinical staff who has received proper supervision working under the direct supervision of a licensed clinician. Treatment is conducted on-site with daily group sessions, weekly individual therapy, monthly family therapy, and psychosocial skills training. The treatment and progress notes were documented on a form which contained all the information in the Department's Counseling and Therapy Progress Note form (MHSA 018). All mental health groups held contained ten or less youth and substance abuse groups contained fifteen or less youth which is in accordance with policy and was confirmed by group sign-sheets and progress notes.

Five youth mental health and substance abuse records were reviewed. The treatment team consisted of the required individuals, as reflected on the individual treatment plan (ITP). During the annual compliance review, treatment team meetings were observed. Treatment team meetings were determined to be supportive of each youth's status while also emphasizing the positive aspects of the youth's behavior and treatment progress. Five staff were interviewed; none of the direct care staff reported facilitating mental health or substance abuse groups. Five youth were interviewed, and all youth reported actively participating in groups. The groups included mental health, substance abuse, anxiety, self-respect, coping skills, grief, and sexual abuse. An informal interview with the designated mental health clinician authority (DMHCA) validated the program's practice of treatment services delivery.

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

The program has a policy and procedures to address the provision of mental health/substance abuse services, which includes treatment and discharge. Five mental health and substance abuse records were reviewed, and all five records contained evidence of admission screening assessments, a file review, and an initial mental health and substance abuse (MHSA) treatment plan. In all records, initial treatment plans were completed on the date of the youth's admission to the program. Each initial treatment plan contained all required elements including the youth's demographic information, reason for treatment, initial diagnostic impression or presenting symptoms, current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses and symptoms, initial treatment methods, and initial treatment goals. Each initial MHSA treatment plan reflected an initial psychiatric evaluation would be completed within fourteen days of

admission. In all five records reviewed, initial psychiatric evaluations were completed within the fourteen-day time period. Psychiatric evaluations were documented on the Clinical Psychotropic Progress Note (CPPN) and included history, a mental status exam, DSM diagnosis, and treatment recommendations.

All five youth records reviewed contained an individualized MHSA treatment plan which was completed within thirty days of the youth's admission to the program. All five individualized treatment plans included all required information, including youth demographics, current DSM diagnoses and symptoms, mental health/substance abuse treatment goals, with documentation of progress made by the youth in meeting each treatment goal, and any changes in mental health and substance abuse treatment methods or interventions, psychiatric services, and strength and needs of both the youth and family. All individualized treatment plans were signed by the staff completing the plan. Three out of five individualized treatment plans were completed by the master's-level non-licensed therapists and were reviewed, signed and approve by designated mental health clinician authority (DMHCA) within ten days of completion. The other two individualized treatment plans were completed by the DMHCA.

Treatment plans were reviewed every thirty days for all five records reviewed. Treatment plan reviews documented each youth's progress towards identified goals and objectives which was prescribed in youth's treatment plan. Additionally, all treatment plan reviews contained all the required criteria; a current DSM diagnosis and symptoms, mental health/substance abuse treatment goals with documentation of progress made by the youth in meeting each treatment goal, and any changes in mental health/substance abuse treatment methods or interventions, and psychiatric evaluations, and recommendations which provides for all required elements. Two of the five mental health and substance abuse records reviewed were applicable for youth currently taking psychotropic medication. The two applicable youth's individualized treatment plans contained goals and objectives pertaining to medication management.

Three closed mental health and substance abuse records were reviewed. All three closed records contained the documentation of the youth's discharge instructions to include the discharge summary were discussed at the youth's exit staffing and signed by both the youth and their assigned therapist. The closed records also provided documentation to support a copy of the discharge summary was provided to the youth's parent/guardian and the youth's juvenile probation officer.

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

The program has a policy and procedures to address the provision of mental health and substance abuse services, which includes specialized intensive mental health treatment services. Intensive mental health treatment services are delivered seven days a week to include: daily group therapy, individual therapy weekly, and monthly family sessions.

Youth with co-occurring substance abuse disorders receive requisite treatment services. There are therapeutic activities provided seven days a week. The program contracts with a licensed psychiatrist and a backup psychiatric advanced practice registered nurse (APRN) who provide on-site psychiatric services every week. There is one licensed therapist who serves as the clinical director and who is on-site Monday through Friday, for a minimum of forty hours a

week. Each of the five reviewed youth mental health and substance abuse records had documentation to verify the provision of specialized services in accordance with the program's contract with the Department. The facility administrator was interviewed and reported the program provides intensive mental health services to all youth in the program.

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

The program has a policy and procedures to regulate the provision of mental health and substance abuse services to included psychiatric services for applicable youth. The program has an agreement with a psychiatrist and a backup psychiatric advanced practice registered nurse (APRN) to provide on-site weekly psychiatric services. The psychiatric APRN works under the direct supervision of the psychiatrist. The psychiatrist collaborative practice protocol was available for review upon arrival and is maintained on-site. The psychiatrist's license expires January 31, 2021, and the psychiatric APRN's license expires July 31, 2020. Reviewed documentation validated either the psychiatrist or psychiatric APRN had been on-site weekly for the past six months. The psychiatrist is available twenty-four hours a day, seven days a week for emergency consultation. The psychiatrist or psychiatric APRN meet weekly with the clinical staff to discuss the progress of youth prescribed psychotropic medication, as well as to review the needs of new youth in the program. An interview with the psychiatrist confirmed the program's practice. Psychiatric services include the completion of psychiatric evaluations, participation in treatment planning, and supervision of the treatment for youth who are prescribed psychotropic medications in collaboration with the designated mental health clinician authority (DMHCA) and the program's health services administrator (HSA). Program policy requires each youth to receive a referral for a psychiatric evaluation which must be completed within fourteen days of admission. Psychiatric evaluations are to be documented on the Clinical Psychotropic Progress Note (CPPN) which include the youth's history, a mental status exam, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, and treatment recommendations.

Five mental health and substance abuse records were reviewed, and determined the program completed an initial psychiatric interview on all youth within fourteen days of admission. All CPPNs contained the required elements and each section was completed appropriately. When psychotropic medication was prescribed or continued, the CPPN contained the name of the medication, an explanation of the need for the medication, frequency of dosage and medication monitoring requirements. Three youth out of five were applicable for taking psychotropic medications. The accompanying CPPNs for these youth records contained all required elements to address medications. Documentation was reviewed for each youth taking prescribed medications and supported each youth received medication management from the psychiatrist or psychiatric APRN at least once every thirty days and new prescriptions were written by the psychiatrist.

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 policy and plan to describe the program's procedures for prevention of suicide. The plan is an attachment to a policy. The plan provides information about the program's suicide prevention procedures, as well as the identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response and a process to review suicide attempts. The program's suicide prevention plan is reviewed annually; the plan was reviewed by the facility administrator and the designated mental health clinician authority on December 24, 2018.

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 policy and procedures to address the provision of mental health and substance abuse services which includes suicide prevention services. The policy requires the administration of an Assessment of Suicide Risk (ASR) to all admitted youth, regardless of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) results. All five reviewed youth mental health and substance abuse records contained a completed ASR which was administered during the admission process. None of the five youth required further assessments on the MAYSI-2 for being at risk for suicide; however, all youth were referred for further assessment and evaluation due to the program's policy.

Two of the five reviewed youth mental health and substance abuse records were applicable for suicide prevention services; therefore, one additional record was reviewed. Each of the three applicable youth were placed on constant supervision and referred for an Assessment of Suicide Risk (ASR) based on staff observations. The program completed an ASR within twenty-four hours; each ASR was completed on the required form which contains all the required criteria. The ASRs were completed by a licensed clinician, or a non-licensed clinician who had completed the required twenty hours of training and the five supervised suicide risk assessments. Additionally, ASRs were either completed by or reviewed by a licensed mental health clinician within the required timeframe. As a result of the ASR, two youth were continued on constant supervision and the third youth was stepped directly to standard supervision. For the two youth who remained on precautionary observation, follow-up ASRs were conducted until such time the youth could be stepped down to close supervision. All three records of youth placed on suicide prevention services contained parent/guardian and juvenile probation officer telephonic notification which was documented on each the ASR form. All three ASRs

documented consultation between the licensed clinician and the facility administrator. Precautionary observation logs were reviewed for each of the three youth placed on heightened supervision. Logs were filled out in their entirety and reflected each youth was properly supervised during the duration of placement on precautionary observation. Reviewed documentation validated youth were provided supportive mental health services, and placement of youth on precautionary observation did not limit or restrict the youth to their sleeping area and allowed them to participate in select activities with other youth in the designated safe housing areas. Alerts were immediately entered into the Department's Juvenile Justice Information System (JJIS) upon placement and the alerts were promptly closed upon the youth being stepped down from precautionary observation. A review of logbooks reflected the three youth reviewed being placed on precautionary observation and being stepped down as well.

The program maintains two suicide response kits, one in master control and one in the medical clinic, which contained a knife-for-life, needle nose pliers, and wire cutters. Five staff were interviewed regarding their responsibilities for a youth expressing suicidal thoughts; all staff stated they would keep the youth in constant sight and sound, and immediately start documenting youth supervision. All five staff reported they would immediately notify mental health staff and search the youth and the room for sharp objects. All five staff reported the suicide response kit was maintained in master control, three reported a kit is also maintained in the medical clinic, and two reported a kit was also maintained in the employee break room. The three youth who were placed on precautionary observation were interviewed and all three youth reported always being with staff and never left alone.

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 suicide precaution observation logs for three youth placed on precautionary and/or secure observation were reviewed. One applicable youth from the original five youth sample was reviewed and two additional applicable records were pulled in order to review the required three records for suicide precaution observations logs. Each log documented designated safe housing areas, necessary restrictions, and warning signed. Staff observations of youth were documented every thirty minutes in real time. Each reviewed log documented mental health clinical staff and administration were notified. Each log was reviewed and signed by the shift supervisors and signed by mental health clinicians to document their daily review of the logs. The program uses the Department's form, and each is printed in different colored paper for staff to easily distinguish between levels of supervision. Three youth previously placed on suicide precautions were interviewed. Each confirmed they were never left alone while on observation and staff was always with them.

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

Five staff in-service staff training records were reviewed and all five had documentation of at least six hours of training in suicide prevention. Mock suicide and mental health emergency drills were reviewed for the four quarters uring the period of October 1, 2019 through October

8, 2019. The program conducted a total of fifteen drills during this time frame. All drills were conducted quarterly with all shifts, except for one quarter, on one shift. Two drills accidently were held on first shift in the third quarter, as one was intended for second shift but was held thirty minutes prior to second shifts arrival due to management oversight. Drill participation was reviewed for fifty percent of direct care staff, the results show all fifty percent participated in at least one drill each quarter. There was one part-time staff member reviewed who did not review suicide drills during the quarters they worked. All mock drills included emergency response to a suicide attempt or self-inflicted injury and methods for contacting other program staff, medical personnel, and emergency medical services in addition to the use of a first aid kit and/or suicide response kit. Each reviewed staff participated in at least one drill which included the demonstration of cardiopulmonary resuscitation (CPR) techniques. The program has two suicide response kits, one at the medical clinic and one in master control. Both kits were inspected and found to contain wire cutters, suicide rescue tool, needle-nose pliers, and a one-way CPR mask. During an interview with the facility administrator, it was indicated drills are scheduled monthly on each shift and attempts are made to ensure each staff member participates in one drill every quarter.

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 plan detailing crisis intervention procedures which includes elements related to notification and alert system, means of referral, including youth self-referral, communication, levels of supervision, documentation and a review process. The crisis intervention plan was reviewed and signed by the facility administrator on December 24, 2018.

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.	

A review of five youth mental health and substance abuse records were reviewed. None of the five reviewed records were applicable for having a crisis assessment completed since the last annual compliance review; therefore, three additional records were reviewed. The program provided three additional records for review which were the only applicable records since the last annual compliance review. The three requested crisis assessments were either completed by a licensed clinician or a non-licensed clinician, followed by a review by a licensed clinician

within the required twenty-four-hour period. In all three records, the youth was seen within two hours of being determined to be in crisis. Each assessment included the reason for the assessment, a mental status exam and interview, the determination of danger to self and/or others, clinical impressions, recommendations of treatment, supervision levels, and follow-up or further evaluation. The crisis intervention plan includes procedures for the notification of the youth's parent/guardian. Parental notification was required and completed for two youth and one youth did not require parental notification due to no change in supervision status. Mental health alerts were entered for the two applicable youth, as they were placed on precautionary observation as a result of completing the crisis assessment. The two youth placed on precautionary observation remained on precautionary observations status until the completion of a follow-up mental health examination was conducted by the licensed mental health clinician or non-licensed clinician under supervision of the clinical director. None of the crisis interventions were Prison Rape Elimination Act (PREA) related; therefore, no ongoing mental treatment services consistent with the community level of care were required.

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 policy and procedures to address the provision of mental health and substance abuse services which includes emergency services. The program's facility operating procedures include a written emergency mental health and substance abuse services plan. The plan provides information about the program's emergency mental health and substance abuse procedures, immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transportation, documentation, training, and review process. The program plan was signed by the facility administrator and the designated mental health clinician authority (DMHCA) on December 24, 2018.

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

The program has a policy and procedures regarding youth who require Baker or Marchman Act services while in the program. Five youth mental health and substance abuse records were reviewed, and none were applicable for Baker or Marchman Act services. Upon request, the program provided the only youth record which required these services since the last annual review. The youth was placed on one-to-one supervision until the youth was Baker Acted and transported to an off-site provider. An Assessment of Suicide Risk (ASR) was completed upon re-entry and youth was properly transitioned to a lower level of supervision after the licensed mental health professional and the facility administrator conferred and agreed with the reduction of supervision.

Standard 4: Health Services

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

The program has a policy and procedures to identify the authority responsible for provision of health-related services for youth, which includes the provision of a designated health authority (DHA). The program has a contract with a licensed physician (MD) who holds a clear and active license in the State of Florida, which expires on January 31, 2021. The physician's specialty training is in internal medicine, serves as the program's DHA, and is clinically responsible for the healthcare of all youth at the program. The program has procedures to provide coverage during scheduled absences of the contracted DHA. The program maintains a contract with another MD to provide back-up coverage for the DHA. This MD holds a clear and active license in the State of Florida, which expires on January 31, 2021. The back-up DHA provides clinical services during the absence of the DHA. The DHA is scheduled to be on-site at the program two hours a week, and on-call twenty-four hours a day, seven days a week. The program does not utilize a physician's assistant or an advanced registered nurse practitioner to provide coverage. A review of the sign-in/sign-out logs confirmed the DHA or back-up DHA was on-site weekly for two hours for the past six months, with no lapses in coverage. An interview with the DHA confirmed clinical responsibilities include youth initial exams, sick calls, periodic evaluations, and referrals to a specialist as needed. Also, the DHA reports he is on-site weekly, available by phone, and has an answering service for medical staff to communicate youth needs.

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

The program has facility operating procedures (FOP) for all health-related procedures and protocols to address health services provided to the youth. The FOPs were reviewed and updated on June 21, 2019, by the program's designated health authority (DHA) and by the facility administrator on June 18, 2019. FOPs regarding psychotropic medication management were reviewed by the psychiatrist and facility administrator on June 18, 2019. All healthcare FOPs were reviewed by the healthcare staff in October 2019, as evidenced by their signature on the cover page. Documentation confirmed the newly hired nurse signed the treatment protocols in October 2019. The annual DHA protocols were signed June 21, 2019, with no documented changes.

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

The program has a policy and procedures to address the Authority for Evaluation and Treatment (AET) for all youth receiving health-related services. Five youth Individual Healthcare Records (IHCRs) were reviewed and all included a legible AET with the word "copy" stamped on the document. Two youth turned eighteen while in the program, and each had a signed AET limiting parental notification to emergencies. One youth was under the care of the Department of Children and Families; however, the parent(s)/guardian(s) continued to have legal rights of the

youth. According to the nursing interview, medical and case management staff coordinate to ensure each youth has a valid AET prior to arrival of the youth. If a youth does not have a valid AET, then the juvenile probation officer will be contacted by case management staff to obtain a new AET. Documentation in the each IHCR reviewed found copies of parental notifications behind the AET.

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

The program has a policy and procedures to address parental notifications/consents. A review of five youth Individual Healthcare Records (IHCR) found all records included parental notifications for over-the-counter medications beyond those covered by the Authority for Evaluation and Treatment (AET). None of the youth were applicable to receive vaccinations/immunizations, as all youth received required vaccinations prior to entering the program. Documentation confirmed two of the five reviewed youth records indicated significant changes to existing medications and each had the required parental consents. Three of the five IHCRs included changes to youth medications for chronic conditions and parental notification/consent was documented. The remaining two youth turned eighteen while in the program and no longer required parental notification. In four of the five reviewed IHCRs, documentation found four included notification to the parent(s)/guardian(s) by telephone and in writing for off-site emergency care. The other youth turned eighteen while in the program and no longer required parental consent. Two applicable youth were taken off-site for invasive or non-routine dental procedures and each record documented the required parental consents. Three applicable youth were taken off-site for medical treatment and each had the required notifications.

Three youth were applicable for new medication changes, and each IHCR documented verbal notification attempts documented in the progress notes. Medical staff sends written notification to all parent(s)/guardian(s) regardless of telephone notifications and all telephone notifications were witnessed by other required staff members. One youth was jointly served by the Department of Children and Families (DCF) and the program provided two additional DCF served youth to complete the sample size. Documentation in each DCF served youth IHCR confirmed the parental rights were not terminated. Four applicable youth records indicated parent/guardian verbal consent for psychotropic medication changes were obtained and documented on page three of the Clinical Psychotropic Progress Note (CPPN). In each of the four applicable records, written consent was documented on the Acknowledgement of Receipt of the CPPN. Documentation in each of the four applicable records confirmed the notification was sent by certified mail to request parent/guardian consents. None of the reviewed DCF served youth required a court order to prescribe or change psychotropic medications as each parent(s)/guardian(s) continued to have legal rights of the youth.

A review of five youth records found all vaccinations were verified within thirty days of the youth's admission through the Florida Shots website. None of the reviewed IHCRs indicated a need for a Religious Exemption from Immunization form. An interview with the registered nurse (RN) confirmed parent(s)/guardian(s) are contacted by telephone to inform them of a new medication for youth, emergency care, or if a situation warrants contact within twenty-four hours. The RN indicated verbal consents are obtained from the parent/guardian as soon as possible after the designated health authority (DHA) documents a medication order. The RN also confirmed if a youth has an illness or injury requiring emergency medical services, all pertinent

individuals are notified of emergency transportation, and upon arrival back to the program are given an update regarding the youth.

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

The program has a policy and procedures ensuring each youth receives a healthcare screening and evaluation upon admission and ensures a healthcare admission rescreening is completed each time there is a change in physical custody of youth. A review of five youth Individual Healthcare Records (IHCR) supported each youth received an initial admission screening utilizing the Department's Facility Entry Physical Health Screening (FEHPS) form. All admission screenings were completed by a licensed practical nurse (LPN). An interview with the registered nurse (RN) indicated the initial healthcare admission screening occurs immediately following the youth's initial search. The licensed nursing staff notifies the designated health authority (DHA) of all admissions, regardless of conditions, following the completion of admission documentation within twenty-four hours. The DHA is notified by telephone or verbally of any medical conditions identified within one hour of a youth's admission. A review of five youth IHCRs indicated one youth had a change in physical custody since arriving to the program. A new FEHPS form was completed for this youth within twenty-four hours of return to the program by the LPN. A review of the chronological progress notes revealed consents and results of pregnancy screening was completed for any sexually active females.

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

The program has a policy and procedures ensuring youth shall be oriented to the healthcare system upon admission or at the next available opportunity. A review of the program's facility operating procedures found the program provides an orientation of access to medical care, Sick Call, what constitutes an emergency, medication process including side effect monitoring, the right to refuse care, what to do in the case of sexual assault or attempted sexual assault, and the non-disciplinary role of the health care provider. A review of five youth Individual Healthcare Records (IHCR) validated each youth received a healthcare orientation on the day of admission, as documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for female adolescents. A review of the health education packet confirmed the youth and nursing staff signed acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth received health education throughout their stay documented in the youth's IHCR. A review of the Health Care Contacts confirmed the information was accurate.

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

The program's practice is for the designated health authority (DHA) to be notified by telephone, by answering service, or verbally if on-site of all admissions. Additionally, when a youth is

admitted on prescribed psychotropic medications, the psychiatrist is notified by telephone. The notifications are documented by the nursing staff on the DHA Notification of Admission form. Nursing staff signs the form and the DHA signs the form at the next scheduled on-site visit. A review five youth Individual Healthcare Records (IHCRs) confirmed the DHA was notified by telephone of each youth's admission to the program. All notifications to the DHA were documented on the Nursing Chronological Progress Notes of the youth's IHCR.

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

The program has a policy and procedures to ensure nursing staff complete the Department's Health-Related History (HRH) form prior to the completion of the Comprehensive Physical Assessment (CPA). A review of five youth Individual Healthcare Records (IHCR) indicated the HRH form was completed on the day of admission for all youth. The HRH form was completed by a licensed nurse in all IHCRs. The designated health authority (DHA) documented a review of the HRH form, as indicated on the CPA and the focused note on the admission documentation. An interview with the registered nurse (RN) confirmed all healthcare staff are responsible for completing the HRH form upon admission and annually, as needed.

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

The program has a policy and procedures to ensure youth receive physical health evaluations subsequent to admission to the program. The program also has a policy and procedures ensuring each youth receives routine health care screenings and evaluations upon admission to the program for latent or active tuberculosis. A review of five youth Individual Healthcare Records (IHCRs) found the program utilizes the Department's Comprehensive Physical Assessment (CPA) form. All CPAs were completed by the designated health authority (DHA) or the back-up DHA within seven days of admission. All sections of the CPA were completed in full utilizing the "O" or an "X" including the appropriate medical grade of one through five, with one exception. One youth CPA did not have documentation of the Tanner stage. This youth was referred for a routine gynecological exam; however, program practice is for no youth to receive a routine gynecological exam. The back-up DHA scheduled the youth for a routine gynecological exam and the DHA discontinued the order upon returning to the program. The DHA will document the appropriate documentation deferring the gynecological exam in the comments section of the CPA. All youth are offered access to a pelvic and gynecological exams, which are conducted off-site, by physicians at the Pasco County Health Department. The Department's Problem List was updated in all five reviewed IHCRs. At least one verified Tuberculosis Skin Test (TST) was documented in all reviewed IHCRs within the last year, and all youth were assessed prior to being placed in general population. Each of the TST results were documented on the CPA form. An interview with the registered nurse indicated youth records are reviewed prior to and at admission to ensure a current TST was completed on each youth. A positive protein derivative (PPD) is administered annually for all youth and due dates are maintained by nursing staff. Any youth who may need follow-up are transported to a local emergency room for evaluation prior to being placed in general population. All documentation is recorded on the Facility Entry Physical Health Screening form and the Infectious and Communicable Disease forms.

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

The program has a policy and procedures ensuring all youth admitted to the program are to be clinically screened and medically evaluated for sexually transmitted infections (STI). The policy requires all youth admitted to the program for possible Sexually Transmitted Diseases to be screened utilizing the Department's Sexually Transmitted Infections Screening form. Five youth Individual Healthcare Records (IHCRs) were reviewed and found each youth was screened at admission. Due to the results of the screening, each youth was referred by the designated health authority (DHA) to the Pasco County Health Department for testing. STI testing results were documented in the lab section of each youth's IHCR and on the Infection and Communicable Disease (ICD) form. The program has a policy and procedures ensuring youth receive testing, counseling, and referrals for treatment for any youth at risk for human immunodeficiency virus (HIV). A review of five youth IHCRs documented each of the youth was offered counseling and testing for HIV. The program maintains an agreement with the Pasco County Health Department to provide a certified counselor. All youth records indicated the youth received testing by a certified HIV counselor. A copy of the consent for HIV testing for each youth was maintained in the IHCR. In addition, each youth's pre and post-test counseling was documented on the Individual Health Education Record and in the progress notes. All youth HIV results were filed confidentially in a sealed envelope marked "confidential" consistent with F.S. 381.004. No youth test results were documented in the medical alerts. During interviews with five youth, all youth confirmed they could receive an HIV test if requested.

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

The program has a policy and procedures to ensure youth can make a sick call request and have their complaints treated through a sick call system. The policy addresses sick call care, to include dental complaints for all youth. The program's policy requires any youth who complains of a similar sick call three times within a two-week period to be referred to the designated health authority (DHA). The program conducts sick call Monday through Friday, between 1:55 p.m. and 2:30 p.m., and on Saturday and Sunday between 12:30 p.m. and 1:00 p.m. In the event a youth has a sick call complaint, the youth requests a Sick Call Request form to complete and place in the in a locked box located in the dining hall. Each youth is oriented to the program's sick call process upon admission. All sick call requests are reviewed by the licensed nursing staff within two hours while on-site. The program's policy indicates only licensed health care staff may conduct sick call. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into a shift supervisor for review. The shift supervisor will determine if the sick call requires immediate attention. The DHA is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. A review of five youth Individual Healthcare Records (IHCR) found each youth submitted a Sick Call Request form. None of the youth presented with a similar sick call complaint three or more times within a two-week timeframe. All reviewed IHCRs indicated the Sick Call Request forms were filed in the progress notes in reverse chronological order. Each of the sick call events were conducted by a

licensed practical nurse, then reviewed daily either telephonically or in person with DHA or the registered nurse. All Sick Call Request forms and progress notes were documented in accordance with Health Services Rule 63M-2. All reviewed sick calls were documented on the Sick Call Index, with one exception. Each of the reviewed sick calls were documented on the Sick Call Referral log. One sick call was observed with the youth's permission during the annual compliance review. Observations validated the youth was seen by a licensed medical professional in a confidential manner. A youth care worker was positioned outside of the medical office to allow the youth to have privacy. Five youth were interviewed and each reported being able to see a doctor or dentist, if needed. Four of the five interviewed youth reported being able to be seen within one day for a sick call request, one reported within three days. Five staff were interviewed regarding who conducts sick call at the program, each reported the nurse or the doctor.

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

The program has a policy and procedures to provide episodic care and first aid to youth. A review of five youth healthcare records found all youth required episodic and/or first aid care during their stay in the program. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Nursing staff also maintained an Episodic/First Aid/Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Log.

The program maintains a policy to ensure the automated external defibrillators (AED) are properly managed and administered to youth eight years of age or older who experience sudden cardiac arrest. The program maintains two AEDs located in the medical office and the shift breakroom. Nursing staff ensure the AEDs are functioning adequately and conduct inspections to ensure the batteries and pads are in working order. Observations of the nursing staff testing the AED to were observed by the annual compliance review team member. A review of the AED located in the medical office confirmed the batteries were last changed in June 2016 and expire June 2020. A review of the AED in the shift break room confirmed the batteries were last changed in April 2019 and expire April 2023. Documentation of the AED located in the medical office confirmed the pads were last changed in April 2019 and expire on June 2020. Documentation of the AED located in the shift break room confirmed the pads were last changed in April 2019 and expire on June 2021. The program maintains eight first aid kits located in medical, shift breakroom, master control, kitchen, classrooms one and two, and two kits utilized for transportation. A review of three first aid kits confirmed each contained the contents of items approved by the DHA. All kits are checked weekly by the nursing staff to ensure there are no expired contents. The program maintains two suicide responds kits located in medical and the shift breakroom. Observations of each kit found each contained a knife-for-life, wire cutters, and needle nose pliers. All AED and suicide response kits are checked monthly to ensure the appropriate contents are available and in working order. A review of the training records for non-health care staff found each maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. Nursing staff have current certifications in CPR and AED. A review of training records confirmed shift supervisors have been trained in the administration of the epinephrine auto-injector.

The program conducts announced and unannounced emergency medical drills monthly on each shift. A review of medical drill documentation for the previous twelve months confirmed drills were conducted monthly, on each shift, and included CPR/AED demonstration at least quarterly. Observations during the program tour found postings of staff rights and responsibility to contact 9-1-1 in the event of an emergency. Emergency numbers were in master control and the medical office, which included the number for the statewide Poison Information Center. The location of the emergency contact lists are in areas not accessible to youth. Interviews with five staff confirmed staff are permitted to call 9-1-1 from any of the supervisors' telephones at any time.

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

The program has a policy and procedures to ensure referrals and coordination of medical care to an off-site healthcare provider is provided to the youth in a timely manner. Evaluations conducted off-site are recorded on the Department's Summary of Off-site Care form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth Individual Healthcare Records (IHCR) were reviewed and none were applicable; therefore, three additional records were requested for review. Each of the three applicable IHCRs indicated the youth required off-site emergency care. All three applicable youth IHCRs indicated notification was made either by telephone or by mail. The Department's Summary of Off-site Care forms and discharge documents were located in all three records. The DHA reviewed and initialed all off-site care findings, instructions, and information. Two applicable youth required referrals, and each was documented on the physician's order sheet. In one of the two applicable records there was no documentation of additional appointments being tracked and completed, as required.

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

The program has a policy and procedures to address youth who have chronic conditions to ensure youth receive regularly scheduled evaluations and follow-ups. The nursing staff utilize a medical tracker for documenting to ensure youth with chronic conditions are evaluated periodically prior to the renewal of any expired medications. A review of five youth Individual Healthcare Records (IHCR) found all youth were identified as possessing a current chronic condition. None of the youth were identified as having a communicable disease. Four of the five youth were applicable for taking either over-the-counter or psychotropic medications for their chronic conditions. Two of the five youth were identified as undergoing treatment for a physical health condition which includes a Body Mass Index greater than thirty. Each of the applicable youth with chronic conditions were classified with the appropriate medical grade of two through five. Reviewed documentation confirmed all applicable youth were placed on the chronic conditions list and received the appropriate periodic evaluations every ninety days. None of the youth with a chronic condition were applicable for a specialized treatment plan. There were no youth taking anti-tuberculosis medications and none of the youth were identified as being pregnant. All periodic evaluations were maintained in the youth's IHCR. In one applicable youth

IHCR, a periodic evaluation was required prior to the renewal of an expired medication, which was conducted at the appropriate time. All periodic evaluations were conducted on-site and were appropriately documented in the IHCR chronological progress notes. There were no indications of lapses in care or missed periodic evaluations. The Department's Problem List was updated for each youth. An interview with the designated health authority confirmed he conducts periodic evaluations for youth with chronic conditions every sixty days. An interview with the facility administrator confirms there is a process in place for youth to request to see the doctor for any non-emergency medical issues, which is the sick call process and this process is available to youth daily.

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

The program has a policy and procedures to ensure there is no lapse in a youth's medication regimen, and all prescriptions for youth are immediately processed if the medication needs to be immediately initiated. When a youth is admitted to the program with a prescribed medication, the nursing staff ensure the medication is verified and documented utilizing the Facility Entry Physical Health Screening (FEPHS) form, the Health-Related History (HRH) form, and the Comprehensive Physical Assessment (CPA). The nursing staff complete the Authority for Evaluation and Treatment (AET) form for each youth which serves as the authority to continue the present medication(s) and administer medications as ordered. An interview with the registered nurse confirmed only healthcare staff complete medication verifications by reviewing the youth's medical records and verifying with the parent/guardian upon admission. A review of five youth Individual Healthcare Records (IHCR) found four youth were admitted to the program on prescribed medications. The remaining youth was started on over-the-counter (OTC) medications upon admission to the program. All records indicated the verification was documented in the chronological progress notes in the youth's IHCR.

The program's practice is to notify the designated health authority (DHA) of all youth admissions. A review of four applicable records confirmed the DHA and psychiatrist were contacted to resume the specified medications youth were prescribed prior to admission, which was documented as received either verbally or by telephone. The remaining youth was not on medications upon admission to the program and therefore did not require contact to the DHA or psychiatrist to resume any medications. A review of the Department's Medication Administration Records (MAR) confirmed the program's practice. A review of documentation confirmed all medications had a current, valid order, and were given pursuant to a current prescription. All five youth IHCRs indicated an OTC medication not listed on the AET were administered according to approved protocols. One youth was applicable for a refusal of medication and it was clearly documented on the MAR and nursing staff completed the Department's Refusal of Treatment form when the youth refused the medication dosage. In all reviewed youth IHCRs, the MAR indicated all medication start and stop dates. Nursing staff initialed each administered medication entry and there were no documented lapses or errors in medication administration. In all reviewed youth IHCRs, nursing staff documented the weekly side effect monitoring on the MAR. There were no standing orders, emergency, or pro-re-nata orders for psychotropic medications. Each reviewed youth IHCR reflected the prescribed medication was continued, discontinued, changed, or a new medication was ordered. In each instance, the practitioner's order clearly documented the medication and dosage. During an observation of medication pass, the Six Rights of Medication Delivery/Administration were maintained for each youth.

Observations during the annual compliance review confirmed all medications were stored in a separate, secure locked area inaccessible to youth. All non-controlled medications, either prescribed or OTC medications, were stored in separate, secure, locked areas inaccessible to youth. Observations confirmed oral medications were not stored with injectable or topical medications. The program maintains two refrigerators on-site which are used for medication only, and each was observed secured. All syringes and sharps were secured in the medical clinic, behind locked cabinets. The program has a contracted pharmacist who comes on-site once a month for disposal of any expired or discontinued medications. Observations during medication pass indicated youth were given topical medications in a cup. One youth walked away from the medication pass area with the medication in a cup and did not return the cup to the nursing staff. Observations found youth with topical medications were not utilizing the medications in front of staff. Discussions with the regional health services administrator and registered nurse indicated staff were unable to determine if youth were taking the topical medications appropriately. Interviews with five youth indicated four youth were taking medications. Each of the four youth confirmed the nurse gives the youth medications during medication pass and procedures were followed to ensure youth swallowed the medication prior to exiting the medication pass area. Interviews with five staff confirmed only nursing staff or certified supervisors are allowed to give medications to youth.

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

The program has a policy and procedures to ensure stock medications are secured and inventoried using a daily and weekly perpetual inventory in a descending count as each sharp is utilized and disposed. All medications are secured in a locked area designed for storage of medications. All controlled medications had a perpetual inventory and were stored separately from other medications. The program has a perpetual and weekly inventory of all sharps and stock over-the-counter (OTC) medications. The program conducts a shift-to-shift inventory count of all controlled substances which is documented on the youth's Individualized Controlled Medication Inventory Record in accordance with Board of Pharmacy regulatory requirements. The program conducts a third shift to first shift count of controlled medications prior to the medical staff beginning medication pass. Documentation confirmed the number of pills, tablets, or dosages remaining after each dosage were documented on the youth's Individualized Controlled Medication Inventory Record. Observations of a count with the registered nurse confirmed the counts matched the ending inventory numbers. An inventory of three over-the-counter medications, three sharps, and two controlled medications was conducted with the registered nurse. There were no discrepancies found during the inventory. Observations of the medication pass area confirmed all controlled medications are stored behind two locks inaccessible to youth. All non-controlled medications prescribed, and OTCs were stored in a separate, secure, locked area inaccessible to youth. Oral medications were not stored with injectable or topical medications. The program had a secure refrigerator stored in the medical clinic specifically for medications requiring refrigeration. Observation of the medication cart confirmed it was clean and organized, as well as stock items were separate from youth specific medications. The program's practice for disposal of medications is to document the destruction of expired or discontinued medications on a quarantine log, which are destroyed once a month with a consultant pharmacist in the presence of a nurse and witness. This practice was confirmed in an interview with the registered nurse.

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

The program has an infection control plan in place to prevent, treat, and report any infections diseases as required by the Occupational Safety and Health Administration (OSHA) and Centers for Disease Control and Prevention (CDC). The infection control plan included all of the required elements. All staff have access to protective equipment and documentation confirmed Standard Universal Precautions are followed by all staff. There were no instances in which the local health department, CDC and/or the Department's Central Communications Center (CCC) should have been notified of an infectious disease. The program director has an established separate file containing any documents for youth or staff which may have experienced and exposure; however, the program has never had any staff or youth which have been exposed. The program has an exposure control plan which is written in accordance with OSHA standards, which is available to all staff. The Exposure Control Plan was reviewed and signed by the designated health authority, facility administrator, and nurses on June 18, 2019. The Exposure Control Plan includes Risk Assessment and Methods of Compliance, as well as a comprehensive process for needle stick post-exposure evaluations. Interview with the program director confirms the program's Exposure Control Plan is located in master control, the nursing office, and a policy book in administration.

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

The program has a policy and procedures to address prenatal care and education. A review of five youth Individual Healthcare Records were reviewed, and none were applicable. The program did not have any applicable records for pregnant youth during the annual compliance review period. If a pregnant youth is admitted, then the program provides youth with the appropriate pre/post-natal and parenting preparation to include the following: alcohol and drug use, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care, birthing process post-partum care, basic baby care, infant development, parenting skills, shaken baby syndrome, anger management, time management, and after care planning. A review of five staff training records for in-service training confirmed staff received the appropriate prenatal and neonatal training. The training was conducted by a licensed nurse.

Standard 5: Safety and Security

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

The program has a policy and procedures addressing youth supervision. The policy for supervision is one staff to six youth during the daytime and one staff to eight youth at nighttime. Both living units had the daily schedule and activity schedule posted. An interview was conducted with the assistant facility administrator (AFA) and a floor staff member regarding procedures when the youth count cannot be reconciled. Both the AFA and floor staff member provided specific instructions on how to handle discrepancies and recounts appropriately. The following observations were conducted: transition from education to lunch, lunch, restroom breaks, transition from education to the dorms, and education. Staff consistently maintained active supervision of youth. Staff searched youth before all movements of youth. Program staff were observed adhering to the daily activity schedule and providing active supervision. Staff were observed within the required ratio of one-to-six during daytime activities and positioning themselves at all times to be able to closely observe the youth. However, during lunch, ratio was one staff to ten youth, briefly, when one staff stepped into the kitchen to fill up water bottles and the facility administrator had also stepped into the kitchen to speak with dietary staff.

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

The program has a written behavior management system (BMS) which provides positive and negative consequences, in a ratio of four-to-one. The BMS includes a process where staff explain to youth the reason for any infractions imposed. The youth are given an opportunity to explain their behavior and reasonable, alternative, acceptable behaviors. The program utilizes grievances, community meetings, and individual meetings for youth to voice their concerns regarding the fair and consistent implementation of the BMS. Negative consequences used by the program include failure to earn points, and for more serious infractions, a referral for a special treatment team meeting which could result in a level freeze. All infractions are reflected on the youth's daily point cards which are documented and reviewed daily with youth and case managers. The special treatment teams provide the appropriate consequence, and ensure the youth understand the expectations to get back on track. An interview with facility administrator confirmed this practice. Five youth were interviewed; the youth indicated staff are consistent with providing rewards and/or consequences. All five youth were able to explain how they can move up in levels. Two youth rated the BMS as very good, two youth rated as good, and one youth rated as fair. Five staff were interviewed; all staff were able to explain the BMS system, as well as identify the types of rewards used in the program for the youths. The facility

administrator (FA) was interviewed concerning the BMS. FA reported program utilizes a behavior management system compiled of a series of levels. The youth complete each level by earning daily points to earn a positive day in the program. Earning positive days allows youth to also participate in nightly incentive. If a youth has a behavioral infraction youth can lose points, after so many deducted points they will not earn enough points to make their positive day which hinders their progression through the level. Additionally, youth can earn a special treatment team referral for more serious behavioral violations. Often these referrals result in "level freeze days" which also extends the youth's progression in the program.

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 on the comprehensive and consistent implementation of the behavior management system (BMS) and training for staff on the understanding and implementation of the BMS. The policy covers protocol where staff provide feedback regarding implementation of the BMS. Position descriptions specified the required qualifications of staff whose job functions include implementation of the BMS. All required parties were involved in the development, implementation, and on-going maintenance of the BMS. The BMS includes a process wherein staff explain to the youth the reason for any sanction imposed prior to the end of the staff member's workday. The program does not utilize room restriction as part of the BMS. The BMS does not include increased length of stay, denial of youth basic rights, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement. Youth are able to earn points daily and can move up to the next level by having multiple positive days. Consequences can include a loss of points or a special treatment team. All five interviewed youth reported they understand the BMS. Five staff were interviewed and confirmed youth are informed of consequences by staff and special treatment team. All five staff also confirmed youth are given opportunities to explain their behavior. Five pre-service and five in-service staff training records indicated staff were trained in the BMS. Records also showed the education staff were jointly trained on the utilization of the BMS during school.

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 policy and procedures addressing the supervision of youth. The program currently has forty-eight cameras, and all forty-eight are active and operational at the time of the annual compliance review. The video footage is stored for thirty days. Video footage and ten-minute check documentation from both living units was reviewed for six randomly selected days.

All dates and dorms had ten-minute checks completed within the required timeframes and in real time. Observations showed staff took the time to walk room-to-room and look into each room for safety and security. The facility administrator explained the timeclock on the video footage is a few minutes off from the clock utilized by the floor staff to complete the ten-minute check observations. This was evident on the youth visual check sheet. Five staff were interviewed, and all staff stated checks are conducted every six minutes when a youth is placed in their room while sleeping or for non-punishment reasons.

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

The program has a policy and procedures for census, counts, and tracking. Documentation was reviewed in the logbooks on eight randomly selected days which reflected counts were completed every hour and documented in the logbook. Counts are recorded in the logbook at the beginning of each shift, after each outdoor activity, and during emergency situations. The logbook also accounts for admissions, transports, and discharges from the program. Eight dates were randomly selected to review formal and informal head counts. The shift report summarizes a twenty-four hour period and captures events, incidents, and activities. It also shows incoming staff were briefed and reviewed the previous shift report. All required information was clearly documented within the shift report to include incidents, special instructions for supervision, population counts, activities, transport, and admission and releases. Five staff were interviewed, and all five staff stated head counts are completed every hour. All of the staff stated any discrepancies will result in a recount until the discrepancy is cleared.

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 for logbook entries. The program has bound logbooks with numbered pages. The logbooks are kept and maintained by the shift supervisor. They do not keep separate logbooks in the dormitories; however, the program summarizes in a shift report the events, incidents, and activities documented in the program's central logbook. The documentation reviewed in the logbooks for sixteen randomly selected dates found all entries

were made in ink with no erasures, had no sign of obliterated or removed verbiage, any errors had a line through it, all entries included the time and name of the staff completing the entry, and the date is listed at the top of each page. The shift report documented a twenty-four hour period and captured events, incidents, special instructions for supervision and monitoring of youth, population counts, perimeter checks, transports, activities, removal of any youth from the mainstream population, admissions and releases, and information related to escapes or attempted escape incidents. It also documented incoming staff were briefed and reviewed the previous shift report. For all dates reviewed, there were no emergency situations, incidents involving mechanical restraints, escapes, or law enforcement requests. CCC and/or Florida Abuse Hotline related incidents were also documented in the log book.

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 which captures key assignments, inventory and tracking, secure storage, procedures addressing missing and damaged keys. Observations during the annual compliance review found master control staff used the wand on all staff and visitors to conduct a search for contraband upon arrival to the program. Program staff took every person's keys, provided a key badge with a number, and ensured all individuals signed into the program. All keys were accounted for, based on a review of the inventory sheet and keys within the key storage area. Six staff members' key rings were reviewed during the annual compliance review. All six keys were secured on a locked ring, and all four staff members had the correctly labeled key ring. The permanent issue log for all six key rings matched the number of keys on the key ring and were labelled correctly. The key box is in a locked room which is manned by master control. The restricted keys were locked in the key box labeled "restricted keys." There were no incidents reported to the Central Communications Center (CCC) regarding key control during the annual compliance review period. The program maintains a key control binder for key inventory. Five staff were interviewed about the key control process. All staff interviewed were able to verbalize the key control process.

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

The program has a policy and procedures addressing contraband procedures. The program has a documented practice to prevent contraband from entering the facility. The facility administrator (FA) was interviewed and was able to provide an explanation of the process of how contraband would be handled and disposed of, following program's policy. A review of the youth handbook and program policy supported the documents meet the required items for identifying contraband. The program policy and procedures cover consequences for contraband, searches of the physical plant, searches of the facility grounds, searches of the youth, and searches of incoming and outgoing mail. The policy also addresses disciplinary action for staff found in possession of contraband and contacting law enforcement when illegal contraband is found. The program maintains a room search log. The logbook was reviewed. The logbook contained a weekly schedule for room searches for the entire year. Each of the weekly room searches for the past six months were reviewed and accounted for in the logbook. The room searches were documented in the logbook and included the date, room number, a section for contraband or unauthorized item, list of items found, reason for confiscation, how the contraband is disposed of, and the staff signature.

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

The program has a policy and procedures regarding searches and full body searches. During the annual compliance review, there were two transports. However, there were no admissions, off campus activities, or visitation. Searches after transport were observed. All of the youth were searched, as required by the Protective Action Response (PAR) training manual, and the required ratio of staff-to-youth was observed. The searches were observed to be a normal practice for the youth and were conducted by a staff member of the same gender. The youth were treated with dignity and respect when being searched. The assistant facility administrator (AFA) was interviewed and reported the youth are searched during every movement at the facility, and this practice was observed during the annual compliance review. Five staff and five

youth were interviewed, and all confirmed youth are searched every time there is a movement of youth.

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

The program has a policy and procedures on vehicles and maintenance. The program has two vans. One van had its annual safety inspection completed on May 24, 2019. The last annual safety inspection was completed on October 5, 2018. No documentation reflecting oil changes and/or general maintenance was provided. This van is currently in use to transport youth. The second van had its annual safety inspection completed on June 21, 2019. The last annual safety inspection was completed on October 5, 2018. The van was taken to the shop on October 31, 2019 for maintenance/repairs and an inspection. Documentation reflected an oil change and general maintenance was completed on June 21, 2019, the date of the annual inspection. This van is currently not in use, as it is in the shop. The first van was observed to be locked when not in use. The facility administrator (FA) was informally interviewed and was able to explain the process of a transport which consisted of a staff signing out the van keys and first aid kit. The youth is taken out of the front door, the van is searched, the youth is helped into the van and secured with a seatbelt, and then the doors are closed and locked. The inside door is unable to be opened from the inside. The annual compliance review team was able to observe a fire extinguisher in the vehicle, the appropriate number of seatbelts, and the seatbelt cutter/window punch was attached to the van keys. The FA reported youth are never attached to the vehicle other than by a seatbelt. A random check of personal vehicles found all vehicles were kept locked when not in use and are located outside of the locked gate.

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

The program has a policy and procedures regarding the transportation of youth. During the annual compliance review, a scheduled transport was observed. A cell phone was provided to the driver by the program. Two female staff were observed transporting one female youth. A random check of personal vehicles found all vehicles were kept locked when not in use and are located outside of the locked gate. The youth do not have access to open the vehicle doors from the inside. An interview with the assistant facility administrator (AFA) revealed youth always wear a seatbelt during transportation and are never attached to any part of the vehicle. Informal interviews were conducted with the facility administrator, and two randomly selected youth, and all three individuals were able to explain the routine staff-to-youth ratios for transports and consistency of seatbelt usage. Five staff were interviewed to ensure staff are provided with a communication device during transports. All five staff indicated staff are provided a cellular phone for transports.

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

The program has a policy and procedures in place explaining who is responsible for conducting weekly security audits, the development and implementation of corrective actions, and an internal system. The program's policy captures the requirements of F.A.C 63E-7.013. Documentation was reviewed which showed during the past six months, twenty-four weekly inspections were conducted a minimum of once a week, four weekly inspections were between one to two days late, and two weekly inspection were missing. In an interview, the facility administrator explained the process regarding identification, tracking, deficiencies, and how deficiencies are addressed. The physical plant manager is responsible for completing all applicable work orders submitted by staff.

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

The program has a policy and procedures addressing the issuance, inventory, and control of equipment and tools. The program maintains an inventory in a binder for class A and B tools. The binder documents all of the tools issued prior to work and after an activity is completed. The policy and procedures mention prohibited tools, missing/lost tool procedures, and how to dispose of dysfunctional tools. Five in-service and five pre-service staff training records were reviewed, and all had documentation to show they received safe tool use training. All class A and B tools are secured behind a locked door. Observations found all tools were accounted for daily, were clearly labeled with numbers and images, and were placed in the respective locations.

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 for youth handling tools and supervision. The policy has verbiage regarding the supervision requirements of youth using tools. The ratio established in the policy is one staff to five youth, and a detailed guide for distribution, collection, and search criteria was listed. An informal interview with the program's regional compliance specialist stated the program does not let youth use Class A tools. Documentation of two youth were reviewed for up-to-date risk assessments and all were eligible to utilize class B tools. Five staff were interviewed, and all demonstrated an understanding of which tools are considered class B and can be utilized by youth at the program. Five youth were interviewed, three out of five youth stated they had utilized tools for lawn maintenance projects with the physical plant manager or during community service outings.

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 specific to external contractors. The written notification and guidelines for outside contractors include tools to be checked upon arrival and departure, tool restrictions, youth being restricted from work areas, and missing tool follow-up. Five outside vendor/contractor packets were reviewed; and all reflected the service dates, invoice dates, and sign-sheet dates all matched. During the annual compliance review, an outside contractor arrived at program and was observed going through the safety protocol. Master control had the contractor complete the written notification and guidelines document and provided the contractor with instructions. The program also provided documentation to support the outside contractors signed in on the day of the job.

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

The program has a policy and procedures for the Continuity of Operations Plan (COOP). Documentation supported the program completed fire drills monthly on each shift for the previous six-month period. The program has also completed an emergency drill monthly covering hostage situations, riots, and bomb threats. The documentation included the type of drill, date and time, and a brief scenario. However, twenty-one of the thirty drills reviewed did not provide a comment, observation, and/or suggestion for improvement on emergency response. Egress plans were found to be located throughout the facility. An interview with the facility administrator (FA), reflected COOP drills are conducted monthly and include chemical, severe weather, and riots/disturbances. According to the FA interview, fire drills are conducted monthly on all three shifts. Five youth were interviewed, and three of the five youth stated they participate in fire drills once a month. One youth stated she participated in fire drills twice a month and the last youth stated there had only been in three fire drills in the past six months. Five staff were interviewed about drills; all staff indicated they participate in monthly fire drills. Staff also indicated participating in drills pertaining to weather, bomb threats, medical and mental health, chemical spills, terrorism, escape, major disturbance, flooding, and hostage situations.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature. *A residential commitment program shall establish and maintain critical identifying information and a current photograph which are easily accessible to verify a youth's identity, as needed, during his or her stay in the program.*	

The program has a policy and procedures for the Continuity of Operations Plan (COOP). The program's annual COOP was reviewed and approved on April 11, 2019 and was signed by all

required Department parties. The program's disaster plan is incorporated into the COOP. The COOP is stored in master control and in the facility administrator's (FA) office. The FA reported all emergency equipment and supplies are kept at the Tampa Residential Facility program location and would be delivered upon a necessary emergency. The program maintains a binder called the Case Management COOP which holds all of the current youths' face sheets and admission cards. The face sheets and admission cards have all the required information needed in the event of an emergency. An interview with the FA indicated a copy of the COOP is located in master control and in the facility administrator's office.

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

The program has a policy and procedures in place for control of hazardous materials. The chemicals are kept behind two locked doors at all times which makes it inaccessible to youth, and a list of approved staff for utilizing the chemicals is attached to the door where the chemicals are stored. During the annual compliance review, three bottles of what seemed to be cleaning chemicals were observed in one of the classrooms. The program was promptly notified, and the chemicals were immediately disposed of and an email was sent to the principal for the school staff reiterating safety and security protocols. The Safety Date Sheets (SDS) matched the current chemicals which are at the facility in the locked storage area, and the inventory sheets matched the number of chemicals observed. The chemical storage, SDS, and inventory contain detergent, cleaners, and laundry dryer sheets.

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

The program has a policy and procedures in place for youth handling and supervision of flammable, poisonous, toxic items, and materials. The policy specifically states youth do not use, handle, or clean-up dangerous chemicals. All chemicals are secured behind locked doors. On the door directly protecting the chemicals is a list of approved staff for handling the chemicals. Five youth were interviewed, two youth reported they use paint, one youth reported using rubbing alcohol, and two youth reported they do not use chemicals or cleaning products. The program also has a policy on preventative and corrective maintenance. Daily preventative inspections are logged in the logbook and a review of the logbook reflected the daily inspections were conducted daily. Weekly inspections are completed by the program administration and

documentation reviewed for the past six-month period indicated the inspections occurred weekly. A copy of the preventative maintenance checklist was provided for the past six months and was found to be complete and accurate. Daily cleaning activities were unable to be observed during the annual compliance review.

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

The program has a policy and procedures in place for the control of hazardous materials. The policy states the physical plant manager is responsible for disposal of hazardous materials. The procedures also indicate the program will dispose of all flammable, toxic, caustic, and poisonous items which can be disposed of on-site, according to Safety Data Sheet (SDS) requirements, and the disposal is to be documented on the applicable disposal form. A review of the physical plant manager's training plan shows they were trained in chemical storage and access, and flammable, poisonous, toxic control. All waste is disposed at the Hillsborough County Waste Management collection center. During the annual compliance review, there were no materials disposed. The program does not keep any hazardous materials at the facility. An interview with facility administrator confirmed the program would dispose of any hazardous materials at the Hillsborough County Waste Management collection center.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures for telephone access, visitations, and correspondence. The rules for visitation are posted on the outside gate of the facility. Each youth has an approved correspondence sheet which has been approved by the youth's juvenile probation officer (JPO) and parent/guardian and is maintained in the youth's case management record. Visitation is held on Saturdays and Sundays. Reviewed visitation documentation for eight random dates and all visitations had a completed visitation documentation summary, a visitation sign-in/sign-out log, and individual search forms. Youth telephone correspondence is documented in each youth's chronological notes. The phone call rules and telephone schedule are posted on the wall in the case management office. A review of five youth case management records found all five records showed weekly phone calls; however, the times were not listed for length of phone call. A mailing correspondence binder is kept which has each youth's approved correspondence sheet. The correspondence for each youth is clearly outlined on the log and

shows incoming and outgoing mail. Five youth were interviewed, and all indicated they are provided opportunities to correspond when their families. The facility administrator (FA) interview explained alternative visitations are made on an individual basis with the case managers or therapists.

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

The program has a policy and procedures for controlled observation. The controlled observation rooms meet the requirements of being thirty-five unencumbered square feet, have a metal door with a shatter-resistant window, no vents, a mattress is placed in the room if a youth is staying overnight, the light fixtures have a shatter-resistant cover over it, there are no electrical outlets, and the light switches are outside of the room. There was a total of seventeen controlled observations over the past six months. Documentation of seven controlled observation were reviewed. One youth was in controlled observation for two hours, two youth were in controlled observation for less than one hour, two youth were in observation over one hour but less than two hours, and two youth were in controlled observation for over three hours. All requirements were met for documentation such as staff inspecting the room and the same gender youth searching the youth.

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

The program has a policy and procedures regarding controlled observation. There was a total of seventeen controlled observations over the last six months. One youth was in controlled observation for two hours, two youth were in controlled observation for less than one hour, two youth were in observation over one hour but less than two hours, and two youth were in controlled observation for over three hours. The facility administrator granted an extension over the three hours in one of the two controlled observations which lasted over three hours and did not in the other. All requirements were met for documentation such as staff inspecting the room, the same gender staff searching the youth, a health care professional of the same gender completing the health status checklist, the youth were advised on the expected behavior for removal, and a supervisor authorized the placement.

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

The program has a policy and procedures for controlled observation safety checks and release procedures. Reviewed documentation for seventeen controlled observation records. All seventeen records reviewed had the first page of the controlled observation report completed and submitted to a supervisor. All seventeen records demonstrated fifteen-minute observations on the observation safety check form. All seventeen records demonstrated written permission from a delegated authority, and the facility administrator approved the release when the threat was no longer imminent. The controlled observations logs were kept in an administrative record

and were found in the individual healthcare records for the sixteen current youth. The last youth had been discharged from the program. All seventeen records were reviewed and signed by the facility administrator within the fourteen-day requirement.

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

The program has a policy and procedures on safety plans and has established safety plans for all youth, as required by the July 1, 2019 mandate. The safety plans include warning signs, the youth's baseline behaviors, crisis recognition, joint development of coping strategies, intervention strategies preferred by the youth, and debriefing preferences. Twenty-two safety plans were reviewed. Nine safety plans were completed on the day of intake. One safety plan was completed within fourteen days of admission. One safety plan was completed eighty days after admission date of July 17, 2019. Twelve safety plans were completed between July, August, September, and October 2019 for those admissions which were prior to July 1, 2019. None of the safety plans were updated every thirty days. Youth were asked if they wanted to change or update their plan, but an updated safety plan was not produced. Five youth were interviewed, and all stated they were involved in the development of their safety plans. Five staff were interviewed about the location of safety plans and the process for reviewing safety plans. All five staff stated safety plans were located in a binder in the staff break room. Three out of five staff interviewed were unsure about the processing of reviewing safety plans, the other two staff stated they are reviewed monthly or when a youth is released from precautionary observation.