STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report
Central Pasco Girls Academy
TrueCore Behavioral Solutions, LLC

2953 Wilson Road
Land O'Lakes, Florida 34639

Review Date(s): October 6-9, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Brenda Comadore, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Marvin Bliss, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Melissa Johnson, Office of Accountability and Program Support, Central Regional Supervisor (Standard 2)
Gregory Mahoum-Nasar, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Ken Myers, Office of Education, Regional Education Coordinator (Standard 2)
Kimberly Myers, DJJ Probation, Circuit 6, Juvenile Probation Officer Supervisor (Standard 2)
Amanda Nelson, Office of Accountability and Program Support, Regional Monitor (Interviews)
Paul Sheffer, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Ron Warrick, Office of Education, Regional Education Coordinator (Standard 2)

Program Name: Central Pasco Girls Academy
Provider Name: TrueCore Behavorial Solutions, LLC
Location: Pasco County / Circuit 6
Review Date(s): October 6-9, 2020

MQI Program Code: 1203
Contract Number: R2102
Number of Beds: 32
Lead Reviewer Code: 172

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

Overall Rating Summary

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The thirty-two bed program, for thirteen to eighteen-year-old females for non-secure commitment, is 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 by the program includes family and individual therapy, conflict resolution, stress management, recreation therapy, anger management, impulse control groups, and Healthy Body and Brain Matters. The 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 per week. The program also has an agreement with a psychologist to provide services weekly. Medical services are offered from 7:00 a.m. to 7:00 p.m., seven days a week and are provided by one registered nurse and two full-time licensed practical nurses (LPN) and three pro re nata (PRN) LPNs. The designated health authority is an 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 five vacant youth care worker positions.

Strengths and Innovative Approaches

- Bay Hope Church provides a mentoring program to each youth in the program. The youth and mentor are matched through a series of interviews and meet and greets. The youth is paired with a mentor based on the mentor's experiences, similarities, and personality types. During the mentorship commitment, the mentor meets with the youth during weekly visitations, Wednesday/Thursday Mentor Lunches, and Mentor Friday. Additionally, mentors assist with activities at the program to include bible study, Family Day holiday activities, and fundraising activities. Youth who are eligible for outings attend church at Bay Hope Church. Steadfast mentoring provides a sewing program for youth at the program. The youth learn to operate a sewing machine to create pillows and small quilts. The group is comprised of three youth, selected by the treatment team. Each youth selected meets risk assessment criteria, on Elegance Level, and perform well in the program. The youth enjoy having the mentors and the spiritual, emotional and physical support they provide.

- Girls for Fitness is a program which started with fifteen youth who petitioned to start a physical fitness group to stay in shape. The group meets on Wednesdays and Saturdays to engage in a total body work-out. The recreational therapist gives the youth exercises which can be done indoors, if needed. A Zumba class, by an outside vendor, has been added to the weekend schedule.

- The program promotes community services and encourages all the youth and staff to participate in community service activities. On-campus, the youth participate in a beautification of the facility, which includes outdoor clean-up and gardening. Youth participated in community service activities which included feeding the homeless at Metropolitan Ministries, assisting Steadfast Mentors with packing care packages for overseas missions, and helping under privileged children in schools. Youth donate crochet items made in the sewing program to the homeless shelters.

Standard 1: Management Accountability

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

The program has a policy and procedures for the completion of initial background screenings for staff, volunteers, mentors, and interns. The program had eleven newly hired staff since the last annual compliance review. There were no volunteers or mentors applicable for an initial background screening. Reviewed documentation supported each of the staff received background screenings completed by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each staff's date of hire, contact with youth, or access to confidential information. There was documentation in all eleven staff records indicating the hiring authority reviewed the Central Communications Center (CCC), Staff Verification System (SVS), and the Florida Department of Law Enforcement's (FDLE) Automatic Training Management System (ATMS) as part of the pre-employment background screening process. All eleven new hired staff were added to the Clearinghouse employment roster. Ten of the eleven were direct-care staff. The remaining new hire was a maintenance staff. The program administered the "Job-Fit Assessment," a pre-employment assessment on each new direct care staff. The assessments were maintained in each staff's personnel record; each staff had received a passing score on the assessment. The teachers are employed by Pasco County Schools; therefore, the clearances were provided through the school district and were completed November 4, 2019. The program has thirty-five active volunteers. An eligible clearance was received prior to starting with the program for all volunteers, which was before this annual compliance review period. An Annual Affidavit of Compliance with Level Two Screening Standards was sent to the Department's Background Screening Unit on December 6, 2019.

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

The program has policy and procedures to address the completion of five-year background rescreenings on staff, contracted staff, volunteers, and mentors. There was one volunteer eligible for a five-year background rescreening and a rescreening was completed prior to the volunteer's five-year anniversary date, with the information submitted to the Department's

Background Screening Unit at least ten days prior to the anniversary date. There were no other staff eligible for a five-year background 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 trauma 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 the staff's understanding of the program's code of conduct. Eleven personnel records were reviewed and 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) phone numbers throughout the program. The youth have access to a telephone in the cafeteria which allows each youth to have direct access to the Florida Abuse Hotline. 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 of the youth reported they always feel safe in the program and have never been denied any basic rights. Two of the five interviewed youth stated they have never heard the staff using profanity. One youth said they heard staff use profanity once. Another youth stated occasionally and the other, stated often. All five youth stated the staff talk respectfully when talking to 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 described, 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. 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 annual TRACE self-assessment and surveys were completed by the program on June 30, 2020. During the annual compliance review, there were no observations of any physical, emotional, or psychological abuse. According to the facility administrator (FA), staff receive pre-service training regarding abuse and CCC reporting during on-boarding, in new hire training. Staff receive annual training on incident reporting as well. All CCC and abuse incidents are reviewed and reported during Morning Management Meetings and is entered into the Morning Meeting Database for tracking.

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 six incidents concerning allegations against staff for incidents of physical, psychological, and/or emotional abuse since the last annual compliance review, of which five were reviewed. Reviewed documentation reflected management immediately initiated an internal investigation and placed the staff member on administrative leave. One incident was substantiated, and the staff involved were terminated or resigned. Prior to termination or resignation, the program placed the staff on administrative leave pending results of the investigation. According to the facility administrator, management responds to abuse allegations immediately, when notified, according to protocol. Additionally, the facility administrator stated management has two hours to ensure the CCC and all applicable parties are contacted.

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 incidents reported to the Department's Central Communications Center (CCC). The program had thirty-one incidents reported to the CCC, of which ten were related to the COVID-19 pandemic or public health emergencies, during the last six months; therefore, the program had a total of twenty-one non- COVID-19 pandemic related incidents, of which five were reviewed. Documentation validated each of the five incidents were 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 all five incidents were documented in the logbook, as required. 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 an increase of the reportable incidents from twenty-one incidents during the same time period last year, to thirty-one incidents this year. The program's facility administrator stated staff receive pre-service training during the on-boarding in new hire training, regarding abuse reporting and CCC. Staff receive annual training on incident reporting. All CCC or abuse incidents are reviewed and discussed during Morning Management Meetings and are entered into the Morning Meeting database for tracking.

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 January 10, 2020. The program had one PAR incident within the last six months. The PAR report reflected a review by a PAR-certified instructor and was processed within the seventy-two hour required time frame by all required parties. Reviewed documentation showed the report documented a post-PAR interview with the youth conducted within thirty minutes of the incident. A review of the PAR incident report and comments by the facility administrator (FA) or designee within seventy-two hours of the incident, was found in the PAR report. The report did not require a PAR medical review. Documentation confirmed the report was processed by a supervisor and a PAR instructor to determine if use of force was consistent with the policy in the PAR report. The PAR incident 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 1.35 to .67. The program's PAR rate during the annual compliance review period was .67, which is below the statewide residential PAR rate of 2.23. Monthly PAR summaries were submitted to the Department within two weeks of the end of each month. In an interview, the FA stated PAR reports are reviewed during Morning Management Meetings and reported for tracking in the Morning Meeting Database. The assistant facility administrator of operations conducts a video review of each incident to ensure proper PAR procedures were followed, there was no use of excessive force, and PAR was a necessary level or response. Four of the five interviewed staff stated they have used PAR. All five stated a PAR report is required to be filled out after every PAR incident.

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 February 7, 2020 and approved on February 17, 2020. 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 all required pre-service training within 180 days of hire. Each of the staff completed 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 contractually required trainings were completed for all five staff reviewed. Documentation reflected all trainings were delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro) within thirty days of training completion.

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 February 7, 2020 and approved on February 17, 2020. Five applicable staff training records, including two training records for supervisory staff, were reviewed for in-service training. Each reviewed staff training record documented staff exceeded the required twenty-four hours of in-service training requirements. Each staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff completed training in professionalism and ethics, including standards of conduct, 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.

Two supervisory 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. The in-service and supervisor trainings were provided in a combination of instructor-led and web-based courses and documented in the Department's Learning System (SkillPro) within thirty days of training completion. 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 licensed nursing staff had the required current certification in CPR with AED. The program had an annual in-service training calendar, which is updated as needed.

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 the grievance process and procedures. The program's policy indicates if the youth requests assistance in filling out the grievance form, the staff, family, peers, or other advocates can help the youth fill out the form or fill it out for them. A review of five 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, the youth 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 (FA) within forty-eight hours. If the youth is not satisfied with the response from the formal grievance, the youth may appeal the decision. The 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. There were six 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. The program maintains completed grievance forms, which are numbered and logged in a centralized binder for up to one year. The binder contained a log of grievance forms submitted by the youth; the forms were in chronological order.

Five staff interviews were conducted in which each staff reported knowledge of the grievance process. Five interviewed youth were aware of the grievance process, knew how to access to grievance forms whenever needed, and could request assistance in filling out the grievance forms, if needed. In an interview, the FA stated all youth are to be treated fairly, respectfully and without discrimination and enjoy all constitutional rights afforded to them under both state and federal law. Filing a grievance shall not result in retaliation or barriers to services. Additionally, there is no time limit for a youth to file a grievance, and there is no requirement which prohibits a youth from filing a grievance if she does not choose to use the informal complaint and resolution steps first.

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. The program utilizes Thinking for a Change (T4C), VOICES, and Impact of Crime (IOC) as the delinquency interventions with each youth placed in groups according to identified individual needs. Interviews with the program's clinical director and facility administrator (FA) confirmed delinquency interventions are delivered by the master's-level therapists and the designated mental health clinician authority (DMHCA).

A review of each designated staff's training records confirmed all staff had appropriate education and qualifications for their respective positions and completed the required training to facilitate delinquency intervention groups. Two direct-care staff provide fidelity monitoring of intervention groups and received the required training. The program's daily schedule reflects delinquency intervention and treatment groups are conducted seven days a week, pursuant to the program's contract. 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 indicated 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.

All five interviewed youth stated they participated in all groups including IOC, VOICES, T4C, grief group, and body image. The FA stated only master's and bachelor's-level staff provide life skills trainings or groups. Youth are matched based on individual needs identified in the pre-classification meeting prior to admission. Upon completion of the Youth Needs Assessment, any necessary changes are made to better accommodate the needs of the youth. For placement in intervention groups, a youth's Residential Assessment for Youth (RAY) is reviewed to determine which group is most beneficial based on their individualized needs. A youth's level of understanding and maturity is taken into account to ensure they will benefit from the material presented. Four of the five youth stated they participate in groups and practice skills learned in groups. The remaining one youth reported not participating in groups.

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 addressing interventions and instruction focusing on developing life and social skill competencies are provided to youth through classroom, group instruction, and hands-on experiences, as well as role-modeled by staff and program administrators. A review of the various curricula documented the youth are provided information regarding how to improve communication, interpersonal, non-violent conflict resolution, anger management, and critical thinking/decision making skills. The daily schedule indicated life skills groups are conducted weekly. 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 staff training records confirmed the program has staff trained to provide all of the required life skills and intervention groups, as well as the mental health and substance abuse groups. A review of group sign-in sheets confirmed the program provided all contractually required groups to youth according to the activity schedule. A review of five youth case management records showed all youth were participating in life and social skills groups and training, as required. In an interview, the clinical director stated the program ensures all services are delivered accordingly by maintaining group schedules, reviewing individual and family notes, and monitoring youth progress during clinical supervision weekly. All five interviewed youth indicated they participate in groups and have been able to use the skills 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. A review of the activity schedule confirmed the program provides Impact of Crime (IOC) groups twice a week in the evenings. Reviewed sign-in sheets reflected groups were held, as required. A review of staff training records showed four staff were trained to facilitate IOC; the facility administrator, a case manager, transition specialist manager, and clinical director. A review of sixteen staff training records confirmed staff received training on restorative justice. A review of five youth case management records reflected all five youth were participating in an IOC group. The annual compliance review team was unable to observe a restorative justice group. In an interview with the facility administrator (FA), the FA stated community service activities are completed on-site and off-site to engage the youth in giving back to the community. Youth have participated in packing hygiene baggies for the homeless, feeding the homeless at Metropolitan Ministries, crocheting and passing out prayer cloths, and packed over 100 gift boxes for children in orphanages overseas. Four of the five interviewed youth stated they participate in role plays focusing on negative peer pressure and positive and negative relationships in IOC.

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 and the program-specific Girls 4 Success model meets the needs of the gender-specific 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 utilizes SAVVY Sisters group, focusing on needs

specific to the female population served by the program. Reviewed group sign-in sheets and five youth interviews confirmed groups were conducted, as prescribed. Interviews with the facility administrator (FA) indicated the program follows the girls matters, gender responsive philosophy. The program provides youth with personal items which allow gender expression, which include meeting the needs of youth who identify as the opposite gender. According to the designated mental health clinical authority (DMHCA), the program offers gender-specific services; delivery of services are ensured by maintaining group schedule, reviewing rosters, and reviewing group notes.

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

The program has a policy and procedures to address the internal alert system. The program has an alert board, located in the staff break room, which provides a list of alerts applicable for each youth and is accessible to all staff but not to youth. There are alerts for medical, mental health, safety/security, food/diet restrictions, and gang affiliations. Alerts are updated, as needed, by the appropriate department. Alerts are posted in medical and the kitchen area for youth with medical and/or dietary allergies. Five case management, five mental health, and five healthcare records were reviewed during the annual compliance review. There was documentation, in all fifteen records, to confirm all alerts were current and alerts had been opened or closed timely. All alerts in the Department's Juvenile Justice Information System were noted to be correct. The facility administrator reported internal alerts are reviewed daily and updated, as appropriate. Each department head is responsible for managing alerts applicable to their department. The internal communication board displays current, open, applicable alerts and is updated, as needed. Internal alert trackers are maintained according to department. All internal alert trackers are reviewed on a weekly basis, during Morning Management Team meetings, for fidelity monitoring. All five staff confirmed they are informed of gang, medical, and mental health alerts by the internal alert board.

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 were 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. Reviewed records validated all the required recent information were 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. All youth records were secured in a locked file cabinet which was marked “Confidential.”

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. The youth advisory board meets monthly with administration. 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. Five interviewed youth stated they could provide feedback and input and understood the process for submitting feedback or input. All five interviewed youth participated in youth advisory boards, Chatty Cathys, youth surveys, and daily meetings as a way of providing input to the program. An interview with the facility administrator (FA) revealed youth are able to provide input or feedback through the Chatty Cathy form, grievance form, and during daily meetings. At minimum, a monthly community circle is held for youth to express issues, concerns, positive information, or feedback. In addition, the youth advisory board is available for the youth to provide input. The youth advisory board meets weekly and any suggestions or input is provided to the FA for review and approval.

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 facility administrator 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. In an interview with the facility administrator (FA), the FA stated letters are mailed to members of the community advisory board to encourage participation in the meetings. Meetings are held quarterly at 11:00 a.m.

The community advisory board provides resources and support to the program. For example, members have helped the program build connections with Metropolitan Ministries for the youth to provide community service by feeding the homeless. The youth have helped with car washes

for raising funds for mission trips. Reviewed documentation of the community advisory board supported the program has an advisory board and the program director solicits active involvement of community partners. There was documentation to support an advisory board meeting was conducted January 30, 2020. This meeting was conducted within the required timeframe of 120 days from the last advisory meeting which was held during the last annual compliance review period in September 2019. The meeting agenda, minutes and participant sign-in sheets for the January meeting was reviewed. This was the only documented advisory board meeting taking place during the annual compliance review period. Two members from the community and three program staff attended the advisory meeting in January. There was reviewed documentation to support advisory board meetings were scheduled for April 30 and July 21, 2020. There was a letter addressed to the community advisory board members attached to each agenda for the April and July dates, indicating the community advisory meeting was postponed until further notice due to the COVID-19 pandemic. There was no documentation to support a parent/guardian whose child was previously involved in the juvenile justice system was included in the invitation to the meetings scheduled for the months of April and July 2020; however, there was documentation to support a parent/guardian whose child was previously involved in the juvenile justice system was included in the invitation to the meetings scheduled for October 22, 2020.

The program provided documentation indicating the community advisory board meeting has been scheduled for October 22, 2020. There were copies of letters and envelopes addressed to the various community board members notifying them of the January meeting. Invitations were sent to representatives from law enforcement, judiciary community, community and business partners, school board, faith based community, a victim advocate, and the lesbian/gay/bi-sexual/transgender/questioning/inquiring (LGBTQI) community. The FA indicated in the event on-site visitation is again canceled by the Department, or if the program experiences a spike in positive COVID-19 cases, the on-site meeting will be canceled and replaced with a Zoom meeting. An interview with a current board member indicated the last community advisory meeting took place in January 2020 due to the COVID-19 pandemic. The board member indicated the program was working with the board members on increasing the number of the board members prior to the COVID-19 pandemic.

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

The program has a policy and procedures in place for the dissemination and availability of information and risk management protocols. The program utilizes several methods to obtain input from staff, youth, and parents to use in the program planning process. According to the facility administrator (FA), the program sends out parent/guardian surveys to receive feedback on the admission process upon intake and an exit survey to provide feedback on the overall experience with the program during the youth's commitment. Youth surveys are conducted quarterly to receive feedback from the youth regarding day-to-day programming. The feedback is utilized to make improvements in practices to enhance parent/guardian involvement or ensure systems are followed, as expected.

The management team meets each morning to discuss a variety of topics to include admissions, releases, incidents, grievances, and staff coverage. The supervisors meet with the assistant facility administrator monthly to discuss items pertaining to specific job duties. The program meets with all program staff once a month. A review of monthly All Staff meeting agendas and minutes documented a meeting had been conducted every month for the last six

months and discussions included policy changes, training, department updates, alerts, and department report results. Documentation also confirmed the program implemented a variety of activities, incentives, outings, and prizes to increase morale and reduce turnover. Incentives include wellness week, employee of the month, referral bonuses, and field day.

In an interview, the FA stated the program has experienced turnover in the clinical department overall. Factors contributing to the turnover has included terminations or resignations; however, many therapists have been promoted within the company after obtaining licenses. Youth care worker vacancies have been constant; however, company recruiters have been assisting facility human resources with recruitment. The program has been focusing on building staff moral through an Employee Moral Committee. The committee plans different "spirit weeks" each month. As a company, company-wide Employee Appreciation Day was recently held to recognize all staff.

All five interviewed staff reported staff meetings occur monthly. All staff mentioned topics discussed during staff meetings included policies, alerts, training, drills, and issues regarding the youth and the program; which was verified by meeting minutes. Three of the five staff reported receiving information from reports, such as the annual compliance review and the Comprehensive Accountability Report (CAR). Four of the five staff reported communication within the program was good or very good. One staff reported communication was fair.

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. During an interview with the facility administrator (FA), the FA stated within ninety days of date of hire, staff are evaluated for performance of job duties. Staff are provided with feedback and areas for improvement. The staff and supervisors develop goals for the year and staff are re-evaluated annually for performance of job duties. Upon promotion, a staff may be re-evaluated. All five interviewed staff confirmed receipt of a ninety-day and annual performance evaluations.

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, which promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation and physical fitness. Activities include yoga, dance, basketball, volleyball, table tennis, fast walking, arts and crafts, playing cards, 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. Five interviewed youth indicated they are provided a variety of activities with varying degrees of mental and physical exertion daily. All five interviewed youth and five interviewed staff indicated youth are provided with at least one hour of large muscle activity and one hour of leisure activity daily. A review of the logbook reflected a minimum of an hour of recreation activity was provided daily for all youth. Five youth records were reviewed and all

youth have wellness goals on the 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 meetings, Chatty Cathy forms, and community circles.

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 committing court. The policy established by the program states the case manager will contact the parent/guardian within twenty-four hours of youth's admission by telephone. All five of the reviewed youth records indicated the youth's parent/guardian was contacted by telephone within the first twenty-four hours, and a letter was sent to the parent/guardian within forty-eight hours of admission. Contact was reflected in the case notes and verified by a letter in each record. The letter advised of youth's admission to the program and included information regarding visitation and phone schedules, gang awareness, grievance procedures, contraband, and information about treatment planning for the youth. In all five of the records reviewed, the case notes reflected the judges, juvenile probation officers, and post-residential services counselor, if applicable were notified on the date of the youth's admission and a letter confirming this information was found in each record.

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 of the reviewed records included a signed orientation checklist and recognition of receiving a handbook. The daily schedule is posted in various locations throughout the facility, and printed on each youth's point card. The orientation consisted of the services available, expectation and responsibilities of the youth, information regarding accessing medical and mental health services, accessing the Florida Abuse Hotline, identification of contraband, and grievance procedures. Orientation included a tour of the facility and introduction to key members of staff, and assignment to treatment team. All five interviewed youth stated orientation included program rules, schedule, and procedures. Each of the youth explained the orientation process.

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

The program has a 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. One of the five records reviewed was applicable for youth eighteen years of age or older. The program provided one open and

one closed record for review. All three applicable youth records contained a consent form signed by the youth prior to release of any 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. The classification forms documented 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).

All five reviewed records indicated the youth were classified during the intake process, prior to assigning each youth to a living unit and sleeping room. A risk reassessment was completed for all five youth monthly and records indicated the youth were reassessed monthly for increase of privileges, participation in work projects, and participation in off campus activities. According to the facility administrator, living unit/room placement is based on alerts identified during the VSAB and admission classification. Based on those alerts, youth will be placed in the most appropriate living unit/ room placement. For example, a youth vulnerable to victimization will not be placed in a room with an aggressive youth; or a youth on security alert would be placed in a room furthest from the main entrance.

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. The program completes a questionnaire for all youth during the admission classification process. The program monitors all youth for potential indicators of gang involvement while in the program, such as gang writing, symbols, or hand gestures. In three of the five records reviewed, the youth were identified as gang members after admission to the program. Three of the five reviewed youth records were applicable for gang affiliation. In all three applicable records, local law enforcement, the youth's home county law enforcement, and education staff were notified of the youth's affiliation. Gang alerts were entered into the Department's Juvenile Justice Information System for all the three applicable records. Two of the three records documented the youth's juvenile probation officers (JPO)

were notified of the youth's gang affiliation. In the remaining applicable record, the JPO was not notified of the gang alert/status.

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 gang prevention and intervention services offered to youth identified as a member of or affiliated with a street gang. Three of the five records reviewed were applicable for youth with gang affiliation. All three applicable records were included in the programs Gang Binder, and included screening assessments, notification letters, alerts entered into the Department's Juvenile Justice Information Systems (JJIS), and gang-related goals on the performance plans. The program has monthly intervention activities, completed by the youth who have been identified with gang affiliation. The program utilizes GANGS – 50+ Stories of Fractured Lives curriculum. Sign-in sheets were reviewed and confirmed groups were held, as required. Each of the youth had performance plan goals which included participation in Gang Intervention activities. According to the facility administrator (FA), staff are trained on a monthly basis, during general staff meetings. For youth gang intervention and prevention strategies, the program follows the Arise Life Skills curriculum. Sign-in sheets were reviewed and confirmed groups were held, as required. Youth complete monthly goals as part of the treatment for case management.

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) are completed within thirty days of a youth's admission. All five reviewed youth records documented a RAY was completed for each youth within thirty days of admission. All five records indicated the RAYs were maintained in the Department's Juvenile Justice Information System (JJIS). Four of the five records reviewed were applicable for a RAY Reassessment. Three of the four reassessments were completed within ninety days of the initial RAY, as required. The remaining one record documented a RAY Reassessment completed ninety-one days from the initial RAY, one day late.

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 ensuring each youth's Youth Needs Assessment Summary (YNAS) is completed within the first thirty days of admission. All five reviewed youth

records contained a YNAS which was completed within the first thirty days of the youth's admission. Each YNAS was 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 a youth's Individual Performance Plan (IPP) within thirty days of a youth's admission. The policy requires the plan be developed after the creation of the Residential Assessment for Youth (RAY) and Youth Needs Assessment Summary (YNAS) and should be created within the first thirty days of youth's admission. The treatment team provides input into the development of the plan. All five reviewed youth records contained a performance plan which was developed after the completion of the RAY and YNAS, and within thirty days of youth's admission. Each of the records documented the performance plan was signed by members of the treatment team and transmitted to the youth's committing judge, juvenile probation officer, parent/guardian, and when applicable, the Department of Children and Families counselor, within ten working days of the completion of the plan.

Three of the five reviewed records included performance plans with goals identifying who was to complete each action, frequency, and target dates. The remaining two records had performance plans with goals identifying who was to complete each action, frequency, and target dates; however, one goal on each plan was missing staff responsibilities. In all five of the records reviewed, the prioritized needs, transition activities and court-ordered sanctions were addressed. All five records included the individualized goals based on prioritized needs reflecting the risk and protective factors identified during the assessment process. All five interviewed youth stated they participated in the development of the performance plan goals and received a copy of the performance plan.

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) Reassessments 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 target date for completion during the last sixty days of the youth's stay in the program. Each youth's IPP was updated in the Department's Juvenile Justice Information System when goals were completed, added, or continued and a copy was printed and placed in the youth's case management record.

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

Four of the five reviewed youth records were applicable for ninety-day performance summaries. All four summaries included information regarding the youth's status for each goal, treatment progress, academic progress, behavior, any significant incidents or events, and when applicable, justification for release. In all four of the applicable records, documentation indicated the youth were provided an opportunity to add comments prior to signing and were provided a copy of the summaries. All four youth records contained the original summary. Each of the records documented a copy of the summary was provided to the youth's committing court, juvenile probation officer, youth, parent/guardian, and Department of Children and Families (DCF), when applicable, within ten working days. Three applicable closed records were reviewed for a release summary. In all three records, documentation indicated the Pre-Release Notifications were sent within forty–five days of release. Each of the parents/guardians were notified of the youth's approved release. In all three applicable records, the Exit Residential Assessment for Youth was completed. Four of the five interviewed youth indicated they received a copy of the performance summary. One youth indicated they did not recall receiving a copy of the summary.

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

The program has policy and procedures which addresses parent/guardian involvement in the case management process. All five reviewed youth records included documentation indicating the parent/guardian was contacted, in writing, and by phone for input during the initial intake, assistance completing the youth needs assessment, and for participation in treatment team, transition, and exit meetings. A review of documentation reflected a copy of the performance plans and performance plan summaries were mailed to the parents/guardians for all five youth. The program has staggered Family Days, in which families may visit and attend family counseling. The program allows extra telephone calls and Skype visits with families due to the COVID19 pandemic. All five interviewed youth stated their parent/guardian is involved during treatment team meetings through a conference call with the team and youth. The facility administrator stated, parents/guardians are involved in youth case management.

Parents/guardians are included in the admission process, admission classification, youth needs assessment and monthly youth treatment team meetings. Youth are provided a weekly telephone calls with parents/guardians.

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.	

In all five youth case management records reviewed, each youth's treatment team leader and therapist were identified. The treatment teams consisted of the case manager, administration, medical department, education, residential, mental health, the youth's juvenile probation officer, and parent/guardian. If applicable, the youth's representative from the Agency for Persons with Disabilities, and Department of Children and Families were included. Documentation for twenty-seven treatment team meetings were reviewed. Documentation for nineteen of the twenty-seven documented treatment teams consisted of the case manager, administration, medical department, education, residential, mental health, juvenile probation officer, and parent/guardian. Seven of the remaining eight forms showed the clinical director signed as both the mental health department and administration representatives. The therapist signed the remaining form as both the mental health department and living unit representatives.

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 plans to be referenced and/or incorporated in the youth's individualized performance plan. Each of the five reviewed youth records documented the youth's education and mental health plans were incorporated into the youth's performance plan. The youth applicable for Department of Children and Families (DCF) involvement had DCF care plans incorporated into the treatment 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 program's policy requires a formal treatment team meeting to occur every thirty days, in which all members participate either in person or by providing written input. A total of fifty-five formal and informal treatment team meetings were documented in the five reviewed youth records. During the meetings, the youth's progress was discussed, along with any behavioral, education, therapeutic, and medical issues. Youth are given feedback from all treatment team members, as well as the opportunity to demonstrate the skills learned. Fifty-one of fifty-five treatment team meetings documented the Residential Assessment for Youth (RAY) Reassessment was reviewed. The remaining four summaries did not include documentation of a review of the RAY Reassessment; however, the program indicated this was a case

management oversight, as the RAY Reassessments were attached to the front of the treatment team summaries. A review of documentation confirmed all of the meetings were conducted within thirty days of the last formal treatment team or informal treatment team. All five interviewed youth stated they are given feedback from all treatment team members, as well as the opportunity to demonstrate the skills learned.

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

The program has policy and procedures addressing career education. The program provides Type 2 career education development which includes personal accountability skills, as well as completing employment applications. The program provides Safe Staff for food handler training. All three closed reviewed youth case management records included a completed employment application, résumé, a calendar identifying an appointment with the youth's local Career Source Center, and documentation to support the youth's parent/guardian and juvenile probation officer were made aware of the youth's vocational plan. Two of the three records contained the youth's birth certificate and State of Florida identification (ID) card. The remaining one record had documentation stating, due to the COVID-19 pandemic restrictions, the youth's parent/guardian was unable to acquire the youth's ID card or mail the birth certificate to the program. In all three youth records, the career courses were age-appropriate and aligned with the educational goals and abilities of the population served. An interview with the lead educator revealed the program offers education services and assessments utilizing My Career Shines. The facility administrator confirmed youth are provided with the opportunity to complete job applications, obtain a state identification card, and complete job applications online prior to release.

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

The program has policy and procedures addressing educational access. The program integrates education into the daily schedule in such a way to ensure the integrity of the required minimum instruction time distributed over a twelve-month period. The district and daily school calendars were reviewed and determined the required 240 days of instruction was incorporated, with six days used for teacher planning. This schedule provided six seventy-minute class periods fulfilling the weekly requirement of twenty-five hours of instructional time. Youth are enrolled in academic courses through the Pasco County School District and receive credit for course completions, as appropriate. An interview with the lead educator verified youth attend school according to the daily schedule. A review of the logbooks and an interview with the lead educator confirmed youth were communicating with teachers through the Zoom platform, due to the COVID-19 pandemic, and given educational material in packets when on the units, during the school schedule. Three of the five interviewed youth stated there are no interruptions during school. The remaining two youth stated there are few interruptions during school.

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

The program has policy and procedures ensuring an educational transition plan is developed upon admission. Three closed youth case management records were reviewed. All three youth records included an individual education transition plan, developed upon admission, and included the youth's post-release goals. All thee youth records documented specific monitoring responsibilities by individuals who were responsible for the reintegration and coordination of the provision of support services post release. Each record contained an Electronic Educational Exit Plan (EEEP) which identified the next educational placement information and input from the post-release school district representative. All three records contained the youth's current educational records to be used for the post-release placement. Four of the five interviewed youth stated they are involved in the development of the educational transition plan. The remaining one youth did not recall the development of an educational transition plan.

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

The program has a policy and procedures to ensure the treatment team is planning for the youth's transition to the community upon release from the program. The five active youth case management records reviewed were not applicable for transition. Three applicable closed case management records were reviewed. Documentation in all three closed records confirmed transition conferences were conducted at least sixty days prior to the youth's targeted release date. The youth treatment team leader, facility administrator or designee, and other pertinent treatment team members attended all reviewed transition conferences. Documentation supported the treatment team members were invited to participate in the meetings. Participants were given the choice to participate in person or by telephone.

There was documentation to support written input was provided to the treatment team leader if the invited member was not available to participate in the meeting. Input into the transition meeting was provided by the youth's juvenile probation officer (JPO), parent/guardian, Department of Children and Families (DCF), and education staff. If participation was not possible, the members were invited to provide written input prior to the meeting. Documentation supported the meeting participants reviewed transition activities, identified additional transitional

activities, target completion dates, any updates needed for the performance plan, and identified persons responsible for completion.

There were no youth identified with a history of human trafficking. If signatures were needed on the transition meeting document, there was documentation to support a copy of the plan was sent with a request for return with the signature. In all three closed records, there was documentation to reflect the program received a Community Re-Entry Team (CRT) meeting invitation and the CRT meeting was conducted prior to the youth's release. In all three youth records, the youth and case manager participated in the CRT meeting.

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

The five active youth case management records reviewed were not applicable for transition. Three closed applicable case management records were reviewed. Documentation in all three closed records confirmed the exit portfolio was discussed during the transition conference. A review of the three exit portfolios determined the transition plan, calendar with all dates, times, and locations of upcoming community appointments, educational/vocational certificates, educational records, transcripts, résumé, and sample employment application were contained in each record. One exit portfolio contained a copy of the youth's social security card and two portfolios had copies of the youth's birth certificate. The program documented the reasons for the missing documentation in the portfolios. One youth was in the custody of the Department of Children and Families (DCF). The program attempted to obtain a state-issued identification card, social security card, and birth certificate for the DCF youth. Each of the records documented the youth's exit portfolio was verified during the exit conference meeting and provided to the youth upon release. Documentation supported all of the the exit portfolios were forwarded to the youth's juvenile probation officers.

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

The program has a policy and procedures to address the transition and exit process. A review of three closed youth case management records supported the exit conference was conducted after the program notified the youth's juvenile probation officer (JPO), parent/guardian, education representative, and other pertinent parties of the meeting. All three exit conferences were held at least fourteen days prior to the youth's release. Reviewed documentation supported each exit conference was documented included 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. One of the three youth was over the age of eighteen; therefore, parental involvement was not applicable. For each youth, the date of admission and date of release matched the dates entered into the Department's Juvenile Justice Information System (JJIS). The exit conference was separate from the Community-Re-Entry Team (CRT) meeting.

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

The program has a policy and procedures requiring safety planning and updating processes for every youth. In all five records reviewed, documentation indicated the safety plans were created upon admission. Documentation confirmed plans were created with input from the youth parent/guardian, program clinical staff, and recommendations from previous or current clinical assessments. Four of the five youth records contained parent/guardian input. The remaining record documented parent/guardian input was not successfully obtained; however, documentation also showed the program's diligence in attempts to obtain parental input. In all five reviewed youth records, the safety plans were reviewed and updated every thirty days during treatment team meetings, and as needed. The safety plans are located in the staff breakroom, and all five interviewed staff identified the location of the plans, and indicated the plans are reviewed regularly. The facility administrator reported safety plans are updated monthly and after any serious event. All five interviewed youth stated they contributed to their safety plan.

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory Compliance
Each facility administrator 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 has a licensed mental health clinician (LMHC) who serves as the designated mental health clinician authority (DMHCA). The DMHCA is employed full-time by the program and is on-site at least forty hours a week. The DMHCA is available twenty-hour hours a day, seven days a week in the event of a mental health or substance abuse emergency. A review of the DMHCA's license found it to be clear and active, with an expiration date of March 31, 2021. An interview with the DMHCA reflected they are responsible for ensuring the timely and accurate completion of the required assessments, evaluations, and treatment plans. The DMHCA ensures the treatment programming at the program complies with all requirements outlined in the program's contract. The DMHCA stated the program utilizes the provider's training director, who is a licensed clinical social worker, to provide coverage in the absence of the DMHCA for the program. A review of the training director's license found it was clear and active, and expires March 31, 2021.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Satisfactory Compliance
The facility administrator 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 licensed clinician is on staff, as well as the provision of mental health/substance abuse services to the youth. The program has a licensed mental health clinician (LMHC) who serves as the designated mental health clinician authority (DMHCA). A review of the DMHCA's license found it to be clear and active, with an expiration date of March 31, 2021. The program utilizes the provider's training director, who is a licensed clinical social worker, to provide coverage in the absence of the DMHCA for the program. A review of the training coordinator's license found it was clear and active and expires March 31, 2021. The program has a LMHC who is available to assist if needed during the absence of a non-licensed clinician. A review of the LMHC's license found it is clear and active and expires March 31, 2021. The program contracts with a school psychologist. The psychologist's license is clear and active and expires November 30, 2021. The program is licensed through the Department of Children and Families in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of April 7, 2021.

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

The program has policy and procedures to ensure metal health and substance abuse staff have the appropriate credentials. The program has four full-time non-licensed clinicians, as well as two additional non-licensed staff who provide services to the youth, as needed. Schedules are staggered to ensure the program has clinical staff present seven days a week. Each of the non-licensed mental clinicians hold master's degrees in relevant fields of study. The program provided documentation reflecting each of the non-licensed staff completed twenty hours of on-the-job-training in assessing suicide risk, mental health crisis intervention, and emergency mental health services.

The reviewed documentation validated each of the non-licensed staff administered five Assessments of Suicide Risk (ASR) or crisis assessments in the physical presence of a licensed mental health professional, which allows the non-licensed staff to conduct and prepare ASRs for approval by a licensed clinician. A review of direct supervision logs for the past six months confirmed all applicable non-licensed mental health clinical staff were provided with at least one hour on-site face-to-face direct supervision by the designated mental health clinician authority (DMHCA), or designee, each week the staff provided services, with two exceptions. The reviewed clinical supervision documentation found the back-up DMHCA did not sign the attendance sheet for clinical supervision which was held for two weeks; however, a review of corresponding clinical supervision documentation validated the meetings occurred.

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

The program has a policy and procedures addressing the comprehensive screening process conducted on each youth at admission. A review of documentation confirmed the program follows the procedures outlined in the policy. A clinician completes a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) on each youth as part of the admission process. Each of the five reviewed youth records contained documentation indicating a MAYSI-2 was completed on the day of admission by a clinician and was entered into the Department's Juvenile Justice Information System.

Each of the reviewed MAYSI-2 assessments were conducted by a trained staff. Reviewed documentation confirmed all available information was reviewed to ensure the staff get a clear picture of the youth's history. The reviewed documentation included each youth's Pre-Disposition Report (PDR), most recent Community Assessment Tool (CAT), and any available psychiatric/psychological reports during the admission process. When the MAYSI-2 indicated a need for further assessment, each youth was referred for further evaluation by the youth's assigned clinician. One of the five records documented concerns of suicide ideation; however, each of the youth received a Victimization and Sexually Aggressive Behavior (VSAB) screening and Assessment of Suicide Risk (ASR) completed the day of admission as part of the program's

assessment process. All five youth were referred for a psychiatric evaluation and were assessed within fourteen days of admission. Interviews with the facility administrator and designated mental health clinician authority (DMHCA) confirmed the program's admission process.

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

The program has policy and procedures addressing comprehensive mental health/substance abuse evaluations. Four of the five reviewed youth mental health records included a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) which indicated a need for further assessment upon admission to the program. The remaining youth was referred for an evaluation, as is required by the program's practice. Three of the five youth records documented a new comprehensive mental health/substance abuse evaluation was completed within thirty calendar days of admission. All were completed by a non-licensed clinician, and each was reviewed by a licensed clinician within ten days of completion, as required.

Each reviewed assessment included the methods of assessment, identifying information, screening procedures, presenting problem, family history, history of abuse/neglect/trauma, behavioral observations, physical health, developmental history, mental health, mental status exam, substance abuse history and treatment, social history, sexual history, vocational skills, independent living skills, strengths, needs, abilities, transitional planning, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, summary of clinical impressions, and treatment recommendations. The remaining two youth records contained a recently updated comprehensive mental health/substance abuse evaluation by a non-licensed clinician within thirty days of admission. Both of these youth were transferred to the program from another commitment program, which is operated by the same contracted provider.

The assigned clinicians updated the original evaluation which had been completed at the prior commitment program, as both programs utilize the same online electronic forms system. Each of the original evaluations were completed within the past twelve months, and had new information added in all applicable sections of the evaluation. Both updated evaluations were reviewed by the designated mental health clinical authority (DMHCA) within ten days of completion. The results of the comprehensive mental health/substance abuse evaluation were used to help develop each youth's individual treatment plan.

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

The program has 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. Each youth is assigned to a treatment team upon admission. A review of five case management records found the specific assignment of a case manager and a therapist to each youth on the classification form. The program's policy designates the remaining members of each youth's treatment team, which includes a member of program administration, a living unit representative, a nurse, education staff, and the parent/guardian, when applicable. A review of treatment team documentation confirmed the team consisted of all required members. The mental health and substance abuse daily service progress notes for all five youth were reviewed. The progress notes were documented on a form which contained all the information found on the Department's Group Progress Note form. The progress notes confirmed all five of the youth received services, as set forth in the individualized treatment plan, with no exceptions found.

Four of the five reviewed youth records contained a copy of a properly executed Authorization for Evaluation and Treatment (AET) form. The remaining youth was involved with the Department of Children and Families and had a court order which allowed the program to provide specific treatment services. Each of the five reviewed records contained a signed Youth Consent for Substance Abuse Treatment form, and a signed Youth Consent for Release of Substance Abuse Treatment Records form. A review of all five youth mental health and substance abuse daily service progress notes, as well as group sign-in sheets, validated mental health groups had no more than ten youth present, and substance abuse groups had no more than fifteen youth during any group sessions.

The program is licensed through the Department of Children and Families (DCF), in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of April 7, 2021. An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides mental health and substance abuse treatment groups, family counseling, individual counseling, and psychosocial skills training. The DMHCA indicated treatment groups are conducted seven days a week, individual counseling occurs no less than once a week for each youth, and family counseling is scheduled at least once a month for each youth. Three of the five interviewed youth confirmed participation in both individual and family counseling. The remaining two youth would not confirm participation in these services. Five interviewed staff all indicated they do not facilitate mental health or substance abuse treatment groups.

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

The program has a policy and procedures addressing treatment planning for all youth. Four of the five reviewed mental health and substance abuse records contained an initial treatment plan which was completed on the day of admission. All of the plans were completed on a form which contained all the elements of the Department's Initial Mental Health/Substance Abuse

Treatment Plan form and were signed by all treatment team members. One of the five plans was completed by a non-licensed clinician, and was reviewed by the designated mental health clinician authority (DMHCA) within ten days of completion, as required. The remaining youth did not have an initial treatment plan completed, as an individualized plan was completed within four days of admission.

All five records contained an individualized treatment plan which was completed within thirty days of admission. Each plan was signed by the treatment team and reviewed by the DMHCA within the required ten-day timeframe. Each plan was completed on a form which contained all required elements found on the Department's Individualized Mental Health/substance Abuse Treatment Plan form. The individualized treatment plans included any psychiatric services, including psychotropic medications and the frequency of monitoring by the psychiatrist, when applicable. Each of the plans documented the youth were to receive weekly individual therapy, daily group therapy, and monthly family therapy. A review of progress notes reflected the youth received services, as stipulated in the treatment plans. Documentation confirmed each of the youth had treatment plan reviews which were completed every thirty days, as required.

Three closed records were reviewed for discharge plans. All three records contained evidence indicating the program completed a Mental Health/Substance Abuse Discharge Summary. Each discharge plan included recommended services for the daily maintenance of the positive improvement in behavioral, emotional, and social skills made by the youth during treatment. The reviewed documentation confirmed these plans were discussed and finalized at the exit conference for each youth. Reviewed documentation confirmed the plans were provided to the youth and parent/guardian upon release. The mental health/substance abuse records, including the Mental Health/Substance Abuse Discharge Summary, were sent to the juvenile probation officer (JPO) within five days of each youth's release from the program.

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 policy and procedures to address the provision of mental health and substance abuse services, which includes specialized intensive mental health treatment services. The contract requires the program to provide intensive mental health treatment services. A review of five youth mental health and substance abuse records confirmed the program completed a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation for each youth within thirty calendar days of admission. Mental health treatment planning begins the day of admission for each youth through the completion of an initial treatment plan. An individualized treatment plan is completed to address the youth's needs no later than thirty-days after admission.

A review of progress notes reflected group therapy is conducted seven days a week, and family therapy is conducted at least monthly for each youth, when applicable. All daily therapeutic activities are conducted by the program's clinicians. The program has weekly visits by the psychiatrist, who is available twenty-four hours a day, and mental health crisis intervention is available, when needed. The program employs a licensed mental health counselor (LMHC) who acts as the designated mental health clinician authority (DMHCA). The DMHCA is on-site five days a week to provide oversight for all clinical services provided. The contracted psychiatrist is

on-site one day a week, for at least two hours, to perform psychiatric evaluations and to conduct medication management visits, as needed.

A review of group progress notes, program schedules, and youth interviews confirmed clinical staff were at the program seven days a week. Nursing staff are at the program from 7:00 a.m. – 7:00 p.m., seven days a week to address any concerns which may arise for the youth in the program. These hours are specified in the program's contract. None of the therapist caseloads were found to exceed twelve youth, which was confirmed through an interview with the DMHCA. The facility administrator confirmed 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 contract with a licensed physician to provide psychiatric services. The psychiatrist has been certified by the American Board of Psychiatry and Neurology in Child and Adolescent Psychiatry. The psychiatrist has a clear and active license, with an expiration date of January 31, 2021. The program has a medical doctor (MD) with a clear and active license expiring on January 31, 2022 who serves as the backup for the psychiatrist. A review of five youth mental health and substance abuse records revealed two of the youth were admitted on psychiatric medications; therefore, the program provided an additional applicable record for review. Program practice is for each youth, regardless of whether psychotropic medications are required, to be referred to the psychiatrist for an initial diagnostic psychiatric interview. A review of the three applicable youth records confirmed each youth was seen by the psychiatrist within the required time frame. Each initial psychiatric diagnostic interview was completed using the program's initial psychiatric evaluation form, which contained all required elements, and incorporated page three of the Department's Clinical Psychotropic Progress Note (CPPN) form. One youth was referred to the psychiatrist for re-evaluation due to concerns identified by staff. Each of the youth were seen within thirty days of the referral, and had a psychiatric evaluation completed by the psychiatrist. All required medication management appointments were completed monthly for each of the three applicable reviewed youth.

The program's contract and intensive mental health requirements indicate the psychiatrist must be on-site weekly to provide services to the youth. The agreement with the program states the psychiatrist will provide services on a weekly basis, and must be available twenty-four hours a day, seven days a week. A review of psychiatric service logs found the psychiatrist, or the backup psychiatrist, were on-site each week for at least two hours during the previous six-month period. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the psychiatrist validated services are provided weekly to include evaluation, medication management, consult liaison with medical staff, psychotherapy, and psychoeducation. The psychiatrist indicated there is good communication with the program, and meetings are held with all available clinical staff during each weekly visit. The psychiatrist did not have any concerns with the healthcare or mental health and substance abuse services provided at the program.

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

The program has a suicide prevention plan detailing the program's suicide prevention procedures. The plan contains all the required elements outlined in the Florida Administrative Code and includes outlines how the program will safely assess and protect youth with elevated risk of suicide in the least restrictive means possible. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, level of supervision, referrals, communication, notification, documentation, immediate staff response, and a review process. The plan was reviewed and signed by both the designated mental health clinician authority (DMHCA) and the facility administrator on November 5, 2019.

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

The program has policy and procedures to address the provision of mental health and substance abuse services which includes suicide prevention services. The program has a suicide prevention plan in place which outlines the methods used for supervising, observing, monitoring, and housing for youth identified through screenings, review of available information, or staff observations. A review of five youth mental health and substance abuse records found each youth was screened for suicide ideation upon admission to the program. One of the five reviewed youth records had a flag for suicide ideation on the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2); however, it is program practice to conduct an Assessment of Suicide Risk (ASR) on each youth during the admission process, regardless of whether any suicide risk factors were identified.

Each of the five youth, four of whom had no risk factors, were evaluated during admission, confirming the program's practice. Each of the youth had an ASR administered by a non-licensed clinician on the day of admission, and each were maintained on standard supervision. All ASRs were completed under the supervision of a licensed professional as evidenced by the licensed staff's signature. Four of the five youth records revealed the youth were placed suicide precautions many times. Six instances of placement on suicide precautions were reviewed. Each of these incidences occurred after the youth's admission and were a result of staff observations, with one exception. One was the result of a youth sharing feelings of self-harm through self-report. Each youth had an ASR completed within twenty-four hours of the youth being identified as at risk. Supervision for all the applicable youth was documented on a Suicide Precautions Observation Form. These forms were completed in their entirety, to include the identification of safe housing areas. A review of each ASR reflected notification was made to the

youth's parent/guardian and assigned juvenile probation officer (JPO), regardless of whether the youth was maintained on suicide precautions or not.

Documentation reviewed for two instances indicated the youth was immediately stepped down to standard supervision. In the other four instances, each youth was seen for a Follow-up Assessment of Suicide Risk (FASR) each day the youth were on precautionary observation, until the decision was made to step the youth down to close supervision. Each youth was stepped down from close supervision through the completion of a Mental Status Exam, as required by the program's policy. The documentation reflected a conference was held with a licensed clinician, when completed by a non-licensed clinician, and the facility administrator/designee prior to reducing the level of supervision in each instance. This was clearly documented on each reviewed form, and the designated mental health authority (DMHCA) signed the form the next time they were on-site, when required. During heightened placement, supervision was documented utilizing the Suicide Precaution Observation Logs and Close Supervision Logs. No lapses in supervision were observed on the reviewed logs. Documentation reflecting the placement status of the youth was found in the master control logbook, and entered as an alert in the Department's Juvenile Justice Information System (JJIS).

Two youth of the five reviewed youth records had evidence indicating the youth were placed in secure observation during the annual compliance review period. Each youth had one placement. The program provided an additional applicable record for review. The reviewed documentation for each of the three instances revealed placement was authorized by the DMHCA. The program has one room specifically used for secure observation. Each of the youth had a Health Status Checklist completed by a member of the same gender, for each placement. The reviewed Suicide Precautionary Observation Logs reflected both the youth and room were searched prior to the placement. Each of the youth were on constant supervision while maintained in secure observation. Each youth had an ASR conducted within eight hours of placement. In each instance, the decision was made to remove the youth from secure observation and place the youth on precautionary observation with constant supervision. Support services were provided, when applicable, and each step down was completed after conferring with the facility administrator/designee and the DMHCA, when applicable. All placements and status changes for youth on any type of heightened supervision were found in the master control logbook and facility shift logbook.

The program has a suicide response kit in master control and in the medical clinic. Each kit was found to include a knife-for-life, wire cutters, and needle nose pliers. All five interviewed staff indicated they will notify the program's clinical staff if a youth expressed suicidal thoughts. Four staff indicated they will also place the youth on precautionary observation and document supervision. Two staff stated they would notify the supervisor or the assistant facility administrator. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, facility procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services.

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

The review of five youth records found four youth had been placed on suicide precautions which required the completion of Suicide Precaution Observation Logs. There were twenty-five logs available for review for these youth. All logs were maintained for the duration each youth was on suicide precautions, and the staff documented the youth's behavior in real time, at intervals which did not exceed thirty minutes. Many of the logs were applicable for the documentation of warning signs. Each of the applicable logs reflected warning signs were documented after notification to the designated mental health clinician authority and the facility administrator/designee. Each of the reviewed Suicide Precaution Observation Logs documented the required reviews by supervisory staff and licensed clinicians. Additionally, the program prints the Suicide Precaution Observation Logs on orange paper making them more noticeable for staff. Informal interviews were conducted with three youth who had been placed on suicide precautions while at the program. Each of the youth indicated staff were always with them during this placement, and they were never left alone while on suicide precautions.

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

The program's suicide prevention plan addresses suicide prevention training. A review of five staff pre-service and five in-service training records found each staff received at least four hours of suicide prevention training. The program's suicide drills were reviewed from the previous twelve months. Each of the drills included the time of the drill, the designated shift, name of the staff who conducted the drill, the nature of the incident, persons involved/function of each, type of medical of care given, type of mental health/crisis intervention provided, the outcome of the incident, the time of response, and any follow-up or corrective action needed. Each drill had a sign-in sheet attached with the names and signatures of all staff who participated in the drill. The program was operating with three different shifts.

A review of drill documentation found at least one suicide drill was conducted on each shift for the previous four quarters. The suicide drill training documentation supported all thirteen of the reviewed staff participated in drills, as required. A review of medical and suicide drills confirmed cardiopulmonary resuscitation (CPR) was used during drills at least once each quarter, on each shift, to allow direct-care staff to practice these skills. Reviewed documentation confirmed the program reviewed drills during the monthly All Staff meetings for staff who were not able to participate in the last drill conducted. Interviews with five staff confirmed suicide and medical emergency drills are conducted monthly. The facility administrator confirmed the program provides training or drills for staff, which includes emergency response to suicide attempts or self-inflicted injury.

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

The program has a comprehensive mental health crisis intervention services plan. The plan ensures the program responds to youth in crisis in the least restrictive means possible, to protect the safety of the youth and others, while maintaining control and safety of the program. The plan contains all the required elements outlined in the Florida Administrative Code and includes a notification and alert system, means of referral including youth self-referral, communication, supervision, and documentation and review of the crisis. The plan was reviewed and signed by both the facility administrator and the designated mental health clinician authority (DMHCA) on November 5, 2019.

3.15 Crisis Assessments (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, or by a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the facility administrator 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.	

Two of the five reviewed mental health and substance abuse records were applicable for a crisis assessment. One of these youth required two separate crisis assessments while at the program. In each instance, the youth were seen within two hours of being determined to be in crisis, when applicable. 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. Two of the reviewed assessments reflected the youth were stepped down to standard supervision upon completion of the Crisis Assessment.

A third youth Crisis Assessment was reviewed. The third assessment indicated the youth was maintained on mental health alert status after completion of the assessment. Supervision for the youth was documented on a Mental Health Alert Log, which the program copies on blue paper for easy identification. The youth was stepped down to standard supervision after completion of a follow-up Mental Status Exam. The crisis intervention plan includes procedures for the notification of the youth's parent/guardian, which was completed for each of three reviewed assessments. All three 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 reviewed assessments, each Crisis Assessment was completed because the youth was an alleged victim in a Prison Rape Elimination Act (PREA) event. A review of all three assessments found the program followed all requirements in completing the initial Crisis Assessment, and each youth was stepped to standard supervision as a result of each assessment. All program procedures were followed, to include mental health staff being available for each youth.

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

The program has a detailed emergency mental health and substance abuse services plan which addresses mental health and substance abuse emergency care. The plan was reviewed and signed by both the designated mental health clinician authority (DMHCA) and the facility administrator on November 5, 2019. The plan contains all the required elements outlined in the Florida Administrative Code and includes the immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, staff training, and a review process for each incident.

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

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

Standard 4: Health Services

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

The program has 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). A review of documentation confirmed the designated health authority (DHA) is a licensed internal medicine physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida. The DHA holds an unrestricted license, in the State of Florida, with an expiration date of January 31, 2021 and had specialty training in internal medicine. A review of sign-in sheets from the previous six months confirmed the DHA was on-site at least two hours a week, with a week defined as the seven-day period beginning on Sunday and ending on Saturday.

Policy dictates, if the DHA is on vacation or a scheduled absence, coverage is arranged with another doctor of equal licensure; however, the DHA would continue to provide the administrative duties of communicating with medical staff regarding the youths' medical needs. Documentation confirmed the backup doctor has equal licensure and is qualified to provide services. Since the last annual compliance review, the backup doctor's services were not required. The DHA is responsible to address youth medical needs, acute medical concerns, emergency care, and coordination of off-site care. The DHA indicated their role at the program is to complete comprehensive physical assessments (CPA) within seven days of admission, complete periodic evaluations, conduct sick calls requiring follow up, participate in developing policy and procedures, and provide on-call services twenty-four hours a day, seven days a week, including holidays.

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. A review of documentation confirmed the designated health authority (DHA), facility administrator, and nurses signed and dated, on June 19, 2020, all respective treatment protocols and medical FOP. New policies or changes in polices were reviewed, signed, and dated by each nurse on the individual policy when changes occurred on June 19, 2020. A review of orientation documentation for new healthcare staff was conducted. Since the last annual compliance review, there have not been any new medical staff members. Approval of treatment protocols or standing procedures were written and authorized by the DHA and were not delegated to any other person. The review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management is performed by the program's psychiatrist. The psychiatrist reviewed and signed FOPs related to psychiatric services and psychotropic medication management on June 19, 2020.

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 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). All five reviewed IHCRs contained a legible copy of the AET with the word “copy” stamped on the form. Copies of parental notifications were located behind the AETs in all five IHCRs. All five AETs were valid for as long as the youth was under the supervision of the Department. One IHCR was applicable for a youth eighteen years of age while in the program.

The program provided the only other applicable record for review. Each of the IHCRs documented the staff had the youth sign a consent for youth eighteen years of age or older. Two youth records were applicable for youth co-served by the Department of Children and Families (DCF) and the Department. Both applicable IHCRs contained a court order allowing for the provisions of routine medical care. The parental notifications were sent to both youth’s DCF case workers. One youth entered the program at the age of seventeen and was placed under DCF care before turning eighteen years old. The same youth record was reviewed for an eighteen year old youth and as a DCF youth. The program did not have any other applicable DCF youth. The health service administrator (HSA) interview indicated the program’s policy for obtaining a new or current AET is to send a request for parent/guardian signature to the parent/guardian or juvenile probation officer (JPO) to obtain signatures to receive medical treatment. For youth who are eighteen years of age or older, the program has a consent for the youth to sign.

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 policy and procedures to address parental notification. The policy requires notification to the youth’s parents/guardians of any new medications, off-site referrals, and medical emergencies. The policy requires additional informed consent for special circumstances such as hospitalizations, surgeries, or other invasive procedures. The program maintains a list of over-the-counter (OTC) medications which were approved by the designated health authority (DHA). The list is sent to all parents/guardians with instructions to sign and return the form to the program and to provide consent for the medications.

A review of five individual healthcare records (IHCR) documented three were applicable for parent/guardian notifications. The remaining two youth were eighteen years of age; therefore, the youth not require parental notifications. All records supported the program informed the youth’s parent/guardian of significant changes in the youth’s condition and obtained consent when new medications and treatments were prescribed. Three youth were sent for off-site non-emergency medical care; one of these youth was eighteen years of age. The two applicable records contained documentation the youth’s parents/guardians were notified. One of five youth was applicable for receiving off-site emergency care; no other applicable youth could be provided for the annual review. The one youth had parental notification conducted by telephone and followed up in writing for the off-site emergency care. Four of five youth records were applicable for changes in psychotropic medication and indicated whenever a psychotropic

medication was initially prescribed, discontinued or drug dosage significantly changed, the parent/guardian verbal consent was documented on page three of the Clinical Psychotropic Progress Note (CPPN). Written consent was also documented on the Acknowledgment of Receipt of the CPPN.

All five IHCRs, showed documentation the vaccinations were verified within thirty days of each youth's admission. There were no youth applicable regarding religious or medical exemption. Two youth were co-served by the Department of Children and Families (DCF) and the Department of Juvenile Justice. There was a court order for each youth to allow for the provisions of routine medical care, to include prescription of psychotropic medications for one of the youth. The parental notifications were sent to the youth's DCF case workers. In each, of the five IHCR, documentation indicated parental notifications were completed by nursing staff when required. A staff member witnessed all telephone attempts and conversations with parents/guardians and signed the chronological progress notes as a witness to the contact. Additionally, there was documentation of the verbal attempts, contacts, and consents in the chronological progress notes of each youth's healthcare record. In an interview, the health service administrator indicated immunizations are obtained from the Department's Juvenile Justice Information System or the Department of Health's Florida Shots website and are reviewed during the admission process.

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 policy and procedures to address healthcare admission screening which requires the completion of a Facility Entry Physical Health Screening (FEPHS) form. The policy requires the FEPHS form to be completed by a medical staff member on the youth's date of admission to the program. All five reviewed youth individual healthcare records (IHCRs) contained a FEPHS form completed on the date of admission by a licensed practical nurse (LPN). Two IHCRs documented the youth had a change in physical custody while in the program. When the youth returned to the program, a new FEPHS form was completed by an LPN on the date each of the two youth returned to the program. All five reviewed youth Chronological Progress Notes confirmed the program received consent to conduct pregnancy screening and the record contained the results for each youth. An interview with the health services administrator (has) confirmed the practice for completing FEHPS forms at admission and re-admission to the program.

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 policy and procedures to address the provisions of healthcare orientation to the youth. The program provides a comprehensive orientation to medical services to youth admitted to the program. The orientation is provided by a nurse on the day of the youth's admission to the program. The orientation is documented by the signatures of the youth and the nurse providing the orientation on the orientation form. All five reviewed youth individual healthcare records confirmed all of the youth received a general care orientation upon admission to the program, which included the topics such as access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process to include side

effects monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care providers. All orientation topics were documented on the Department's form for healthcare education. The posted healthcare contacts were confirmed to be 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 has policy and procedures requiring notification to the designated health authority (DHA) upon a youth's admission to the program, regardless of the youth's medical condition. The program documents all healthcare progress notes, including admission notes, electronically. The following information is documented on the program's nursing chronological admission note: the youth's name, vital signs, allergies, medical grade, the date the youth's comprehensive physical assessment (CPA) is scheduled, whether the youth's immunization record was received and reviewed, any medication the youth was admitted with, whether the youth is pregnant, the date the pregnancy test was completed, date the purified protein derivative (PPD) was taken, and whether the youth was offered an human immunodeficiency virus (HIV) test. The nurse's review of the youth's individual health care record (IHCR) and the Chronic Condition Log for correlation and verification were documented on the admission progress note.

Following the completion of the admission progress note, the nurse conducting the intake completes a written DHA notification. The notification includes the youth's name, date of birth, medical grade, medications, history and current allergies, and chronic conditions. The form is signed and dated by the nurse completing the form and is signed by the DHA on the DHA's next on-site visit to the program. Each contact was made by telephone and was documented on the program's DHA and Psychiatrist Notification of admission form, as well as on the Admission Chronological Progress Note. The psychiatrist was notified for youth who entered the program with psychotropic medication.

All five reviewed IHCRs documenting a referral was made to the DHA telephonically and documented on the chronic condition log. Documentation revealed the DHA was notified of all admissions. None of the youth were admitted to the program requiring an emergency response or notification to the DHA.

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

The program has policy and procedures to address the completion of a Health-Related History (HRH). The policy requires a new or updated HRH to be completed prior to the youth participating in any strenuous activity. Five youth individual healthcare records (IHCRs) were reviewed and each contained a new HRH which was completed by a registered nurse within seven days of admission. Each of the IHCRs documented the HRH was completed before or at the same time as the comprehensive physical assessment (CPA) and the designated health authority documented review of the HRH on the CPA by marking the checkbox. The health service administrator (HSA) interview indicated the nursing staff are responsible for completing the HRH on the day of each youth admission.

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

The program has policy and procedures ensuring the completion of the Department's standardized Comprehensive Physical Assessment (CPA) form for all youth admitted into the program. All five reviewed youth individual healthcare records (IHCRs) revealed the program utilized the Department's CPA form. Each of the IHCRs documented the CPA was completed within the first seven days of the youth's admission by the designated health authority (DHA) and documented the youth's medical grade. All five CPAs were completed in accordance with the Department's Rule requirements and all sections were marked with an "O" or an "X." Any section of the exam which was refused by the youth was marked appropriately and "youth refused" was documented with the youth's signature next to the statement. The Department's Problem List was updated, when necessary.

The program has a policy and procedures to address the completion of tuberculosis screening which requires a Tier 1 screening for tuberculosis to be completed during the completion of the Facility Entry Physical Health Screening (FEPHS) form. All five youth IHCRs included documentation to support a Tuberculin Skin Test (TST) was completed within the last year and the results were recorded on the CPA and Infectious and Communicable Disease (ICD) form. All five youth were assessed prior to placement in the general population. None of the youth required further testing or procedures. Reviewed documentation validated the Department's Problem List was updated, when applicable, for each youth. During an interview, the health service administrator (HSA) confirmed the CPA form is completed within seven days of a youth's admission by the DHA and each youth is screened for tuberculosis at admission. All documentation is recorded on the FEPHS form and the ICD 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 policy and procedures to address sexually transmitted infection (STI) screenings which require the screening of all youth upon admission to the program. There is a standing admission order from the designated health authority (DHA) which requires the nurse completing the admission process to clinically screen the youth. The screening is to be completed utilizing the Department's STI screening form. The DHA will review each completed STI screening form to determine if the youth requires testing. There is a standing order/protocol used for STI testing. The testing is completed with results documented and any required treatment started for the youth. All five reviewed youth individual healthcare records (IHCRs) contained a completed screening and evaluation for STIs.

All five IHCRs documented the youth received testing on the date of admission and the results were documented on the Infectious and Communicable Disease (ICD) form, excluding the human immunodeficiency virus (HIV) results. The referrals, as well as the testing, were documented on the STI form and/or the progress notes. Each of the IHCRs documented the youth was offered HIV counseling and testing; however, only one youth consented and received the HIV test. Two additional applicable youth records were reviewed. For all three applicable youth, consent was maintained in the IHCR. The HIV test results were filed in a confidential

manner, consistent with the Florida Statute, in a sealed envelope marked "Confidential" and were not included in the program's internal alerts. The HIV testing and pre/post counseling were provided by Pasco County Health Department who maintains the 500/501 certification from the Department of Health (DOH). In the event of a positive case, the health department contacts the DHA directly. Five youth were interviewed, and each indicated they could ask for 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 policy and procedures which outlines the provision of sick call to include procedures for when licensed healthcare staff are not on-site. The nurses are on site between 7:00 a.m. to 7:00 p.m. Five youth individual healthcare records (IHCRs) were reviewed and none of the youth presented with similar sick call complaints three or more times within a two-week period or complained of any severe pain with which the staff was unfamiliar. No other youth were applicable during the annual compliance review period. All five youth completed Sick Call Request forms which were placed in a locked box and retrieved by the nursing staff. Each of the IHCRs documented the nurse completed the Sick Call Request form within twenty-four hours and were filed with the progress notes in the IHCR in reverse chronological order. All of the Sick Call Request Forms or progress notes were documented in accordance with the Health Services Rule and each sick call was documented on the Sick Call Index and the Sick Call Referral Log. The program conducts sick call daily, as indicated in the contract and the hours are posted in each of the youth's modules. Sick call is conducted by nursing staff.

One sick call was observed, during the annual compliance review, with the verbal consent of the youth. The youth was escorted by a youth care worker to the clinic, where the youth sat on the exam table. The staff remained outside of the exam room to maintain confidentiality. There were no other youth present. The nurse indicated the reason why the youth was being seen, as it was written on the Sick Call Request Form, and began to question and examine the youth, including taking the youth's vitals. After the examination was concluded, the youth was given a follow-up plan, and a Sick Call Request form to sign. Each of the five interviewed staff indicated the nursing staff conducts sick call. The five interviewed youth indicated they can see a nurse either immediately or within one day of requesting sick call.

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 policy and procedures to address episodic and first aid care for the youth. The program developed a roster to document youth requiring episodic care or first aid treatment. Five youth individual healthcare records (IHCRs) were reviewed and each of the youth required on-site first aid or episodic care. Each of the five IHCRs events were documented on the Episodic Care Log. The emergency numbers were posted within the clinic, in the nurse's office, which is inaccessible to the youth. The program has nine first aid kits; one is maintained in the medical office, one in both classrooms, one in the kitchen, one in the shift breakroom, one in

master control, two designated for the vans, and one in the administration office. The designated health authority (DHA) approved the items placed in the first aid kits.

During the annual compliance review, the contents of three first aid kits were observed (medical office, classroom #2, and administration office). Each kit was sealed and stocked with approved contents. There were no expired items in any of the three reviewed kits. When an item is used in a first aid kit, the item is taken to the medical clinic for replenishment. There was documentation to support a nurse completed a weekly check of each first aid kit for the past six months. The weekly checks were documented on the emergency equipment inspection log. The program has two suicide response kits. Each kit includes a knife-for-life, needle nose pliers, and wire cutters. The suicide response kits were reviewed monthly by a nurse and documented on the emergency equipment inspection log. The program has two automated external defibrillators (AED) which are located in the medical office and shift control room. The medical staff checked both AEDs during the annual compliance review and each were determined to be in working order. The last six months, AED documentation indicated the nurses conducted weekly checks. The AED pads, for both AEDs, expire June 2021 and the batteries expire June 2024 and April 2023, respectively.

A review of the last four quarters of medical drills indicated the program completed at least one quarterly drill on each shift to include first aid care, cardiopulmonary resuscitation (CPR), and/or AED demonstration annually. Five reviewed pre-service and five in-service training records indicated each staff completed CPR, AED, and first aid trainings. Shift supervisors completed epinephrine auto-injector training, as required. Current CPR with AED certifications were found in all licensed healthcare staff records. All five interviewed youth reported being able to see a doctor or dentist, if needed. Five staff were interviewed and indicated they are permitted to call 9-1-1 when a youth is identified with a medical emergency.

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 policy and procedures to address emergency care for the youth which includes the provisions of off-site care. The policy includes notification requirements and the completion of the Summary of Off-Site Care form. Five youth individual healthcare records (IHCRs) were reviewed, of which one was applicable for emergency off-site care events. The program did not have any additional applicable records for review. In the one applicable record, the youth required off-site first aid or emergency care and parental notifications were made, as required. The Summary of Off-Site Care form was utilized to document the event and was filed in the IHCR, as well as the discharge instructions. In the one applicable record, the designated health authority (DHA) reviewed and signed all off-site care findings, instructions, and information. The youth received the required follow-up testing, referral, and care as appropriate. The parental notification was also sent to the parent/guardian.

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 policy and procedures to address monitoring youth with a chronic condition which requires the youth to receive a periodic evaluation at least every two months by a physician. During the healthcare admission process, youth are seen by a nurse and any chronic conditions are documented on the admission progress note in the youth's individual healthcare record (IHCR). All youth are placed on the list to be seen by the designated health authority (DHA) on the DHA's next visit to the program. The program maintains a chronic condition roster. The roster includes the youth's name, date of admission, chronic condition, medications the youth was admitted with, the date of the most recent periodic evaluation, and the due date of the next periodic evaluation. Youth taking psychotropic medications are placed on a separate list to be seen by the psychiatrist for medication management.

All five reviewed IHCRs documented the youth's chronic condition on the Facility Entry Physical Health Screening form. Three youth were undergoing treatment for a physical health condition with a Body Mass Index of greater than thirty. All five youth were classified with medical grade two through five, placed on the chronic illness list, received a specialized treatment plan, and the evaluations were tracked. Each of the youth received periodic evaluations at least every two months, as required. The periodic evaluations were documented and maintained in each IHCR chronological progress notes and there was no indication of lapses in care. All records documented the Department's Problem List was updated in accordance with the Health Services Rule. The DHA reported youth with chronic conditions are evaluated every sixty days and prior to the change of psychotropic medications and no less than every thirty days, when prescribed. An interview with the facility administrator, DHA, and the health service administrator (HSA) confirmed the practice. The HSA stated the evaluations are tracked on an internal log. There were no youth taking anti-tuberculosis medications and none of the youth were identified as being pregnant.

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 policy and procedures outlining the requirements for medication management and includes the process for disposal of unused medication. Three of the five reviewed youth individual healthcare records (IHCRs) were applicable for being admitted with medications. The three applicable IHCRs indicated the youth were taking medications at the time of admission and the medications were verified prior to admission to the program. The Department's Prescription Medication Verification Checklist was utilized. In all three IHCRs, the designated health authority (DHA) and the designated mental health authority (DMHCA) were notified and instructed the medical staff to continue the prescribed medication as indicated.

Four of the five reviewed youth IHCR's were applicable for youth currently taking medications. The medications had a current, valid order/prescription and the standard Department Medication Administration Record (MAR) was utilized to document all medication and treatment. Each MAR clearly indicated medication start and stop dates and staff initialed each medication entry, as well as documented weekly side effect monitoring. In the four applicable IHCRs, the

DHA placed an order on the Practitioner Order Form when a current medication was continued, discontinued, changed, or a new one was ordered. There were no standing orders for psychotropic medications. There were no emergency treatment orders for psychotropic medications. There were no PRN orders for psychotropic medications. Each of the IHCRs documented the youth's refusal to take medication on the refusal form, as well as the MAR. Observations of medication administration confirmed the nursing staff maintained the Six Rights of Medication Delivery/Administration.

The program's clinic was observed. All medications were stored in separate locked areas inaccessible to youth. The medication cart was clean and well organized with separate compartments for oral, injectable, topical, liquids, and controlled medications. The program maintains non-controlled medication and sharps/syringes in the locked medication cart in a locked room, as well as behind locked cabinets and in locked drawers in the clinic. All controlled medications are stored in the locked medication cart in a separate locked box. The program has a small locked refrigerator which is utilized for youth medications requiring refrigeration.

Medication pass for two youth was observed during the annual compliance review. The medication administration occurs in the medical clinic office. The medication cart was placed inside the door and the nurse stood next to the cart. Each youth was escorted to the clinic by direct-care staff, the youth stood on the opposite side of the half door. The nurse's sole responsibility was to provide the medication, as the direct-care staff provided supervision of the youth. There were small cups of water on the medication cart. Each youth approached the cart and stated their name, the prescribed medication taking, and any allergies to the medication. The nurse consulted the youth's MAR, retrieved the correct medication, and placed the medication in a small paper container. After each youth stated their name and medication, each youth was provided a cup of water and the medication. After each youth swallowed the medication, the nurse had the youth cough and open their mouth using a tongue depressor and a check to ensure the youth swallowed the medication. The direct-care staff checked the youth's mouth to further ensure the youth swallowed the medication. The nurse and each youth initialed the MAR. The Six Rights of Medication Delivery/Administration were maintained for each youth. The youth were familiar with the process and appeared to be comfortable with it. The health service administrator (HSA) interview indicated the medication inventory is locked and perpetual and weekly inventories are maintained. The program's practice is to secure controlled substances such as narcotics using double locks on the medication cart. Expired or discontinued medications are destroyed by two nurses and the program has a contract with a consultant pharmacist who comes on a monthly basis for monitoring. Five interviewed staff indicated the nurse dispenses the medication to the youth. Four of the five interviewed youth stated when medication is provided, the nurse will ask the youth to state their name and medication, provide the youth with the medicine, the youth drinks water, and the youth mouth is swabbed to check if the medication was taken. The remaining youth did not take medication.

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

The program has policy and procedures for medication management which includes the process for disposal of unused medication. The procedures address the storage of medication and items defined as sharps, which includes the procedures to be used in the event there are discrepancies in the counts of medications and sharps are noted. The program securely

maintains all prescriptions medications, over-the-counter (OTC) medications, syringes, and sharps in the clinic. The patient-specific prescription medications and a working supply of OTC medications are in the locked medication cart which is maintained in the locked clinic. Documentation confirmed there were weekly and perpetual counts of the sharps and the OTC medications completed by the nurses for the past six months. The inventories for the past six months were reviewed. There were no discrepancies noted.

During the annual compliance review, the counts for three sharps were matched against the current inventory and all counts matched the inventory. Three OTC medications were counted and matched the current inventory. Three prescription medications (two were controlled substances) were counted and all matched the current count of the medication. The nurses were observed conducting a shift-to-shift count of controlled medications prior to the medication pass. All were verified to be accurate. Observations of the medication pass area confirmed all controlled medications are stored behind two locks inaccessible to youth. All non-controlled medications prescribed, and OTC medications 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.

Documentation confirmed inventories with running balances were maintained for all controlled substances with a shift-to-shift inventory conducted by the medical staff and it is documented on the youth's Individualized Controlled Medication Inventory Record. The program has a list of staff who were trained in the assistance to self-administration of medication when nursing staff are not on-site. A review of each of the staff records documented the staff received the training. The nursing staff interview indicated the medication inventory is locked and perpetual and weekly inventories are maintained, as well as their practice to secure controlled substances, such as narcotics, by using double locks on the medication cart.

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.	

Documentation reveals the program has an infection control procedure in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, written in accordance with the Occupational Safety Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The procedures include common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, Tuberculosis, Hepatitis A, B, and C, as well as human immunodeficiency virus (HIV) infectious diseases caused by bloodborne pathogens. Other outbreaks or epidemics caused by any other infectious agent whether spread directly or indirectly, outbreaks of pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA), and other emerging antibiotic-resistant micro-organisms are included, as well as food-borne illnesses, bio-terrorist agents, chemical exposures in the workplace, providing Hepatitis B immunizations for staff, staff having access to protective equipment, staff following standard universal precautions, and a comprehensive process for needle stick post-exposure evaluation.

According to the facility administrator (FA), a separate record is established which will contain all documents for youth and staff if there has been a facility/occupational exposure. The program did not have any instances in which the local county health department, CDC, and/or the Department's Central Communications Center (CCC) had to be notified regarding infectious diseases, any quarantining, or hospitalization. The program's exposure control plan is combined with the infection control procedures and is available to all staff. The plan is reviewed and signed annually by the designated health authority, facility administrator, and nurses and includes risk assessment and methods of compliance. In all five records reviewed, documentation reflected each youth received training to include the prevention of bloodborne pathogens and communicable disease within seven days of admission into the program. A review of five pre-service and five in-service training records indicated all staff received infection control and exposure control training. The FA interview indicated the exposure control plan is located in the clinic.

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 policy and procedures to address the care of pregnant youth. The policy requires the youth to be examined at certain intervals and to receive education pertaining to pregnancy, birth, and child rearing. The program did not have any applicable youth who were pregnant since the last annual compliance review. The medical staff maintains a binder of education materials relating to pregnancy. A review of the binder documented all required topics including alcohol/drug use, smoking, nutrition, sexually transmitted diseases, contraception, birthing process, post-partum care, basic baby care, child/infant development, and parenting skills will be discussed with applicable youth. The program entered into an agreement with a local agency through the Healthy Start Coalition to provide education and support, including information on infant care, lactation, and nutrition. The program's policy and procedures require staff to be trained in pre-natal care. Five pre-service and five in-service staff training records were reviewed. There was documentation to support all staff receive training on the monitoring, observation, and emergency care of pregnant youth. Five interviewed youth stated, they have not received prenatal, obstetrical, or gynecological services.

4.19 Licensed Medical Staff (Critical)	**Satisfactory Compliance**
The designated health authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according Department Rule, as well as facility operating procedures and nursing protocols approved by the DHA.	

Documentation reveals the program is in accordance with the Department's Rule and contract requirements. Daily clinical care is performed by licensed medical staff; registered nurses (RNs) and licensed practical nurses (LPNs), according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according the Department's Rule, as well as facility operating procedures and nursing protocols approved by the designated health authority (DHA). A review of documentation confirmed the licensed nurses are practicing within the Florida Nurse Practice

Act and the applicable Florida Board of Nursing Rules. The program has on-site nursing coverage, which is provided by RNs or, at a minimum, LPNs. Reviewed documentation confirmed the licensed healthcare professional providing the direction to the LPN is responsible for reviewing all medical records daily with the LPN and be available on-call for consultation. A review of documentation reflected the nurse licensure credentials and cardio-pulmonary resuscitation (CPR) certifications are clear and active. The contract requirements are in compliance with specific duties outlined in the contract.

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 policy and procedures addressing youth supervision. According to the policy and procedures, staff-to-youth ratios are as follows: one staff to six youth during awake hours, one staff to eight youth during sleeping hours, and one staff to five youth for off-site activities, visitation, or when separated from the population. Over the course of the four-day annual compliance review, observations of supervision were completed. Staff were observed supervising youth during school hours, in the cafeteria, and youth movement through the facility. Staff were observed to be in compliance with ratio requirement.
A video review of supervision during sleeping hours found the required staff-to-youth ratio was maintained during sleeping hours. The daily schedules were posted in the dorm and cafeteria. The program has a full schedule of activities planned and youth were observed engaged in the activities. Staff were observed escorting youth from one location to another and giving youth prompts to adjust behavior, if needed, and documenting observations on the youth's point sheet. Staff consistently maintained active supervision of youth. Staff searched youth before all movements. There were no significant changes in either youth or staff behaviors during the annual compliance review.

At no time during the annual compliance review were youth observed wandering freely about the program. Each of the five interviewed staff confirmed understanding of the procedures when there is a discrepancy with the count. All the staff indicated the count is reconducted until the count is reconciled and the shift supervisor clears the count. Observations found the counts were conducted at scheduled and unscheduled times and the shift supervisor was able to give an accurate count when asked.

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's behavior management system (BMS) or positive performance system (PPS) fosters accountability for behavior and compliance with the residential community's rules and expectations. The PPS was observed posted in the dorm and cafeteria. The PPS is clearly explained in the resident handbook, which is accessible to youth. The program's PPS details the rules and the positive and negative consequences for actions. Five pre-service training records and five in-service training records were reviewed and indicated all staff training records contained PPS training. All five interviewed staff confirmed training and understanding of the PPS. Informal interviews with staff during the annual compliance review week confirmed

understanding and implementation of the PPS. The orientation checklist documents the PPS is reviewed with the youth.

All five reviewed youth case management records contained a complete orientation checklist. The PPS promotes youth rights, positive and negative consequences, constructive disciplinary action, opportunities for reinforcement, positive dialogue, and peaceful resolutions, as well as provides youth with pro-social acceptable alternative behavior, maintains order and security, and minimizes the separation of youth from the population. Youth have an opportunity to explain their behavior. The PPS is connected to each youth's individual performance and treatment plan goals. The PPS includes a variety of rewards including daily snacks, boutique (point store), verbal praise, special privilege activities, and off-campus incentive trips, special hygiene products, movies, games, and specialized hair styles depending on youth level.

The facility administrator interview confirmed the PPS is a level/point system with daily and weekly incentives. Point cards and levels are reviewed by administration daily during morning management meetings. Three of the five interviewed youth rated the PPS as good. One youth rated the PPS as fair and another one rated the PPS as poor. All five interviewed youth understood the PPS and all five knew the rewards and incentives they can receive as a reward for positive behaviors.

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

The program has a policy and procedures on the comprehensive and consistent implementation of the behavior management system (BMS) and training for staff on the understanding and implementation of the BMS. According to the policy and procedures, the program does not utilize room restriction, which was confirmed by youth and staff interviews and observations. The recreation therapist tracks weekly points earned by youth. At the end of each week, the point sheets are filed in each youth's case management record. Youth and staff interviews confirmed understanding of the positive performance system (PPS).

The facility administrator (FA) interview confirmed rewards are tracked daily and the program tracks the number of youth making their day/week in the PPS database. The FA interview confirmed consequences are monitored during morning management meetings, as well as during special and regular treatment team meetings. The program's PPS does not include increasing a youth's length of stay, denial of basic rights, promotion of group punishment, or disciplinary confinement. All five interviewed youth confirmed they are never punished by other youth. Positive and negative behaviors are reviewed during treatment team meetings and daily circle, where youth and staff discuss the events of the day and behaviors. One of the five interviewed youth rated the system as poor, one interviewed youth rated the PPS system as

fair, and three interviewed youth rated the PPS as good. Each of the five interviewed staff indicated they received feedback on their implementation of the PPS daily and as needed.

The program's PPS includes a process wherein staff explain to the youth the reason for any sanction imposed. Youth are given an opportunity to explain their behavior, and staff and the youth discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternative acceptable behavior. All five interviewed staff confirmed training and understanding of the PPS and indicated there are a variety of rewards and incentives for good behavior. All five stated the PPS is discussed during shift briefings and staff meetings monthly. Five pre-service and five in-service staff training records confirmed staff were trained in BMS.

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

The program has policy and procedures addressing the supervision of youth. The program has forty-five cameras. All forty-five cameras were operational at the time of the annual compliance review. The video coverage is stored for thirty days. The program's practice is to conduct checks of youth in their rooms every eight to ten minutes. Video recordings and ten-minute check sheets were reviewed for three selected dates for the two dorms finding no more than ten minutes passed without the staff actively observing each youth. A total of six hours was reviewed. All check sheets contained the times and staff initials for all checks completed. Three of the five interviewed staff indicated checks are completed every ten-minutes. Two of the interviewed staff indicated checks are completed every six to eight minutes. The facility administrator interview confirmed the program has forty-five cameras with video coverage stored for thirty days.

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. The program's policy and procedures address census, counts, and tracking. Observations throughout the week

of the annual compliance review confirmed counts were completed in accordance with the program's policy and procedures. The program tracks daily census information including the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program in the logbook. Logbooks for the previous six months were reviewed and found no discrepancies with counts or census. Informal and formal counts were observed during the annual compliance review and found they were each conducted as required. All five interviewed staff confirmed staff know the procedures for reconciling the count if there is a discrepancy and when emergency counts are conducted.

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 addressing logbook entries and shift report reviews. A review of the logbooks showed all entries were made in ink. None of the pages were removed or obliterated. Each logbook covers a one-month period. The logbook pages are pre-printed shift reports. The first page of each shift contained staff signatures, certifying staff reviewed both current and previous shift information. Shift supervisors sign verifying review of the two previous shifts and a review during shift debriefing. The logbook pages documented perimeter checks, weather alerts, emergency situations, Central Communications Center (CCC) reports, shift summary notes, incidents, Protective Action Response (PAR) incidents, transports, law enforcement or the Department of Children and Families visits, admissions, releases, youth removed from the mainstream population, escapes or attempted escapes, keys, radios, drills, Prison Rape Elimination Act (PREA) checks, fire safety, scheduled and unscheduled counts, and any calls made to the Florida Abuse Hotline and CCC. Incoming staff review the previous two shifts and the review is documented in the logbook.

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

The program has policy and procedures which captures key assignments, inventory and tracking, secure storage, procedures addressing missing and damaged keys. The program's policy and procedures address distribution, tracking, storage, and overall control and security of keys. A review of the inventory matched the key rings in use. The keys are kept in a secure master control, which is not accessible to youth. Staff must exchange personal keys outside the building and receive assigned work keys prior to entering the facility. Each set of keys has an assigned key hook. Keys are assigned to staff according to their department. Restricted keys, temporary keys, and visitor keys are all kept separate from each other. There was one report regarding broken or damaged keys which were removed from the inventory and marked with an out of circulation chit. There was a work order completed for replacing the broken key. There

were no incidents of lost keys, which was verified by the review of internal incident reports and Central Communications Center (CCC) reports. A random check of three staff key rings confirmed the keys matched inventory. The physical plant manager is responsible for replacing broken or damaged keys. Informal interviews with staff confirmed staff's knowledge of the key rings and assigned keys.

All observations during the annual compliance review week found personal keys were secured and staff were aware of program keys in their possession. Key control logs documented the issuance and return of keys on a consistent basis. All five interviewed staff confirmed staff knowledge of and implementation of key control policies and procedures. Additionally, staff reported if keys were damaged, the supervisor would and submit a maintenance request. An informal interview with the master control operator indicated assigned keys are only assigned by the facility administrator, restricted keys are kept apart from non-restricted keys and only assigned staff can access restricted keys. Master control tracks keys as they are signed out and back in by staff prior to receiving their personal keys.

5.08 Contraband Procedure	Satisfactory Compliance

The program's policy must address illegal contraband and prohibited items.

A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.

The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the facility administrator 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 policy and procedures addressing contraband procedures. The program has a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and youth, which is clearly explained in the program's policy and procedures, and resident handbook. The policy states any staff who is found in possession of contraband in a program will be subject to disciplinary action up to, and including, dismissal, as well as procedures regarding notification of law enforcement for items considered illegal as defined in Florida Statutes. The program defines items and materials considered contraband when found in the possession of youth, provides youth with a list of contraband, and informs youth of the consequences if found with contraband. The prohibited list includes personal cellular telephones and/or equipment and/or electronic devices capable of taking pictures and/or audio/video recordings, which are prohibited in the secure area. Staff and supervisory staff explained the contraband procedures. The contraband notice is posted on the front gate and states law enforcement will be contacted if contraband is brought into the facility. This practice was confirmed through an interview with facility administrator (FA). The FA stated contraband would be logged into a binder for reference and illegal contraband, if brought into

the facility, would result in law enforcement called for disposal. All searches are documented in search binders (visitation, room, and youth). The binders were reviewed and found searches were documented appropriately. There were no incidences of introduction of contraband documented during the annual compliance review period.

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 policy and procedures addressing searches and full body searches. Observations during the annual compliance review found searches were completed prior to and after movement from one area to another. There were no scheduled transports during the annual compliance review. Observations found searches were conducted in a manner which treated the youth with dignity and respect. Searches were conducted in accordance with the Protective Action Response (PAR) training manual. Five interviewed youth indicated searches are competed after every movement, off-campus trips, outdoor activities, when items are missing, after visitation, and after meals. Five interviewed staff reported searches are conducted before and after every movement.

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

The program has policy and procedures addressing vehicles and maintenance. The program has two fifteen passenger vans. Both vans are currently in use and had an annual safety inspection. Both vehicles were inspected and confirmed passenger doors cannot be opened from inside. Observations confirmed each of the vans were secured when not in use. The two vans used for transports contained a fire extinguisher, seat belt cutter, window punch, and appropriate number of seat belts. Each van had an assigned first aid kit, which is kept in master control. There were no transports scheduled during the annual compliance review. Both the third shift supervisor and the facility administrator explained the staff-to-youth ratio and all procedures when transporting youth. A check of all the cars in the parking lot found all the cars were locked. All five interviewed staff stated the correct staff-to-youth ratio, the correct safety equipment in vans, process of contraband searches, and emergency response process during a transport.

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 policy and procedures regarding the transportation of youth. The program's policy and procedures were reviewed and found to ensure compliance of all requirements outlined by the Department relating to transportation of youth and driver eligibility. There were

no scheduled transports during the annual compliance review. Both the third shift supervisor and the facility administrator explained the staff-to-youth ratio and all procedures when transporting youth. A check of all the cars in the parking lot found all cars were locked.

An approved driver list was posted in the master control with staff who have current valid driver's licenses. The transport binder was reviewed. All transport orders were completed and documented searches and vehicle's safety, ratio maintained during transports, cellular telephone, first-aid kit, and transporters the same gender as youth. Five interviewed staff confirmed youth are not transported in staff's personal vehicles. Staff indicated they are issued a facility cellular telephone and radio during transports, and a first-aid kit is taken on all transports. Each of the staff reported the vehicles are searched prior to the transport for contraband. Staff indicated they are to maintain a one-to-five ratio; however, transports always have a minimum of two staff. Transporting staff explained what they are required to do in the case of an emergency. All five interviewed youth indicated they felt safe when staff transported them and never saw contraband placed into the transporting vehicle.

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

The program has 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 policy and procedures designate the physical plant manager as the staff responsible for conducting the weekly safety and security audits. The weekly safety audits are kept in a binder, which was reviewed. During the annual compliance review period, there was one inspection missing in April 2020. The forms documented safety and maintenance repairs needed and the dates and times the repairs were completed, or due to be completed. All forms were reviewed and signed by the facility administrator. The forms cover radios, cameras, keys, telephones, mechanical restraints, the generator, flashlights, fire safety equipment, alarms, ensuring no anchor points, youth rooms, recreation area, grounds, correction action needed, and corrective action completed. The interview completed by the facility administrator confirmed the weekly safety audits are conducted in accordance with program policy and procedures.

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

The program has policy and procedures addressing the issuance, inventory, and control of equipment and tools. The policy classifies tools as class A and class B tools, with class A tools having sharp edges and/or considered more dangerous, and class B tools being cleaning items, such as mops and brooms. All observations during the annual compliance review week found all tools were secured when not in use. Class B tools were in secured closets. All the class B tools matched the inventory. Class A tools in the kitchen were observed to be in a locked cabinet in the food manager's office. The kitchen and food managers office are not accessible to youth. The class A tools are on shadow boards and are inventoried. The inventories were reviewed and were complete.

A check of class A tools in the kitchen and in the maintenance area was conducted and found all items matched the inventory lists. The physical plant manager indicated there was one report of damaged or dysfunctional tools. This tool was removed from the inventory and an out of

inventory chit was placed on the shadow board designating it is out for replacement. Documentation indicated the tool was disposed of offsite and a replacement has been ordered. Five interviewed staff indicated youth are only allowed to use Class B tools, such as a broom, mop, or scrub brush.

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 policy and procedures in place to ensure youth use tools safely and are supervised appropriately to prevent injuries to the youth, peers, and staff. The orientation checklist addresses the use of tools and training on use of tools. Each of the five reviewed youth records contained a completed orientation checklist. Youth do not participate in vocational activities requiring the use of tools. Youth risk assessments for off-campus activities and use of class B tools are maintained in a binder. The binder was reviewed, and all forms were completed according to the program's policy and procedures. Each of the five interviewed youth stated the youth use scrub brushes, mops, and brooms.

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 policy and procedures addressing when an outside contractor or worker enters the program to perform a work project requiring the use of tools. The program restricts tools to those necessary, checks tools upon the worker's arrival and departure, restricts youth access to the work area, ensures immediate reporting of any tool the worker cannot locate, and follows-up if any tool is missing. Personal cellular telephones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area. The program's policy and procedures outline who is responsible for providing approval/permissions if such items are required. The program maintains a binder which contains all notice of tool equipment instruction forms, which the outside contractor must sign. The binder was reviewed. The dates of the work invoices matched the sign-in sheets of the outside contractors. The tool notice forms addressed the following: tools checked upon arrival and departure, tool restrictions while in the facility, youth restricted from the work area, and missing tool follow-up. Outside contractors are required to sign the notice of tool equipment instructions form.

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

The program has policy and procedures for the Continuity of Operations Plan (COOP). Drills are conducted in accordance with the program's disaster plan or COOP and facility operating procedures. Fire drills are conducted monthly on each shift. The program has been operating on three eight hour shifts and each had a drill completed for the past six months. The drill documentation included the types of drills, dates and times of the drills, participants, brief scenarios, and findings/recommendations. Fire evacuation routes and egress plans were observed posted throughout the facility. The program conducted fire, safety, evacuation, and

disaster drills during the past twelve months, in accordance with the COOP. All five interviewed youth knew what to do in case of fire and have participated in a drill. All five interviewed staff reported participation in weather, bomb threat, escape, fire, medical, riot and suicide, terrorism, flooding and hostage situation drills. The facility administrator reported fire drills are conducted monthly, on each shift and COOP drills are conducted quarterly on each shift.

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 policy and procedures for the Continuity of Operations Plan (COOP). The COOP is located in the staff breakroom and administration. The program's annual COOP was reviewed and approved on March 24, 2020 and was signed by all required Department parties. The plan addresses alternative housing plans approved by the applicable Department regional director/designee. The COOP addresses fire prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The program conducts COOP drills on each shift. The drill documentation included the types of drills, dates and times of the drills, participants, brief scenarios, findings/recommendations, and pictures. The drills included escape, hostage situation, fire, chemical, flooding, terrorism, bomb threat, evacuation, and severe weather. The program has food and necessary supplies readily available in case of emergency evacuation. The program maintains an administrative hard-copy files on youth in case of emergency with all required information which are located in case management. The facility administrator reported the COOP is located in the staff breakroom and administration which is accessible to all staff.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The facility administrator 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 policy and procedures for the storage and inventory of flammable, poisonous, and toxic items and materials. Chemicals are secured and inventoried as outlined in the program's policy and procedures. All chemicals were observed to be secured during the annual compliance review. The flammable items are stored in a locked cabinet behind the maintenance shed. Cleaning chemicals are in a locked closet located in the staff break room and administration building. Inventories in each area were reviewed. The inventory in the maintenance area was accurate. The inventory in the shift break room and administration building was current and up-to-date. Safety data sheets were in each area where chemicals were stored in a binder with a matching picture of the chemical. The safety data sheets matched the chemicals in each storage area.

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 policy and procedures in place for youth handling and supervision of flammable, poisonous, toxic items, and materials. The program maintains strict control of flammable, poisonous, and toxic items and materials. All chemicals are secured behind locked doors. The program policy and procedures indicated youth are not allowed to or have access to chemicals. Observations throughout the annual compliance review week confirmed the youth do not use or have access to the chemicals. Five youth were interviewed regarding the use of Youth interviews confirmed the youth do not use or have access to chemicals these materials. Each of the five interviewed youth reported they do not use any chemicals.

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

The program has policy and procedures addressing the disposal of flammable, toxic, caustic, and poisonous items are in accordance with Occupational Safety and Health Administration (OSHA) Standards. The policy and procedures identify program positions, titles, or functions authorized to dispose of these items. The physical plant manager is responsible for the disposal of all hazardous waste and/or solid waste and has received training for disposing hazardous items and toxic materials. The physical plant manager has not had to dispose of any chemicals. The program has a contract with a grease removal company, who removes the cooking grease monthly. The physical plant manager indicated if they had waste to dispose of, he would take it to the county's hazardous waste site. The facility administrator reported waste is disposed of safely, using approved vendors, and the item is documented to include the way it was disposed.

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 policy and procedures to allow visitation and communication for youth while in the program. The visitation procedures are posted on the front gate and on the wall in the lobby. The visitation and communication procedures are covered in the resident handbook and addressed on the orientation checklist. Each of the five interviewed youth confirmed they have opportunities to contact family by telephone, mail, and during visitation. The visitation schedule was posted throughout the program.

The program did not offer visitation for the months of March, April, and May 2020 due to the COVID-19 pandemic. Visitation resumed in June 2020. There were seven visitation days to review and documentation indicated visitors signed in upon entry, provided identification prior to entry, and were searched prior to entry. Documentation indicated the visitation area was searched prior to and after visitation as well as the youth. Visitation was stopped again due to

the COVID-19 pandemic for July and August 2020. However, alternative measures, such as FaceTime, Zoom, and Skype visitations were implemented to provide remote visitation and contact. Youth were provided additional telephone calls and extra time on the telephone.

The program began offering visitation again in September 2020 and there was a total of four visitation days. Documentation indicated visitors signed in upon entry, provided identification prior to entry and were searched prior to entry. Documentation indicated the visitation area was searched prior to and after visitation, as well as the youth. The visitation, telephone, and correspondence logs were reviewed. The logs reflected prior to the COVID-19 pandemic and following the approval for visitation to begin again, youth had contact with only approved persons. Incoming and outgoing mail is searched and recorded in the correspondence logs. There were no youth applicable for a history of human trafficking; therefore, the program is not required to request clarification from youth's juvenile probation officer about any parent/guardian past or current human trafficking investigation involvement.

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 policy and procedures for the search and inspection of the controlled observation room. The program utilized controlled observation twelve times in the past six months. The rooms used for controlled observation meets all requirements. Three controlled observation reports were reviewed. In all three reports, staff documented an inspection of the room and a search of the youth before the youth was placed in the room.

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 policy and procedures for controlled observation. Three controlled observation reports were reviewed. In all reports, the supervisory or higher-level staff authorized placement. In all instances, the youth were displaying active aggression, violent behavior, physically uncooperative, and staff advised the youth of the reason of placement in controlled observation and the expected behavior for removal. Each of the reports documented a healthcare professional or staff of the same gender as the youth completed the health status checklist. There were no youth in controlled observation for over two hours during the annual compliance review period.

5.25 Controlled Observation Safety Checks Release Procedures	**Satisfactory Compliance**
The program shall conduct safety checks for youth on Controlled Observation. The facility administrator 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 policy and procedures for controlled observation safety checks and releases. Three controlled observation reports were reviewed. In all three reports, the staff making the placement completed the first page of the controlled observation report and submitted it to a supervisor. Staff documented safety checks at least every ten minutes and observations of the youth's behavior. Staff documented all safety checks and observations on the controlled

observation safety checks form. The facility administrator (FA) or supervisor who has delegated authority gave written approval before the youth was released from controlled observation in all three reports. The controlled observation report, health status checklist, and controlled observation safety checks were maintained in an administrative file. The assistant facility administrator (AFA) or designee reviewed and approved all three controlled observation reports within fourteen days of the youth's release from controlled observation.