STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Crestview Youth Academy (Secure)

Youth Opportunity Investments, LLC

(Contract Provider)
449 StraightLine Road
Crestview, Florida 32539

Review Date(s): March 10-13, 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:

Patrick M McKinstry, Office of Program Accountability, Lead Reviewer (Standard 1)
Tara Frazier, Office of Program Accountability, Operation Review Specialist (Interviews)
Lea Herring, Office of Program Accountability, Operation Review Specialist (Standard 3)
Julie Johnson, Probation Circuit 1, Senior Juvenile Probation Officer (Standard 2)
Craig Swain, Office of Program Accountability, Operation Review Specialist (Standard 4)
Cheri Williams, AMIKids Pensacola, Executive Director (Standard 5)

Program Name: Crestview Youth Academy (Secure)
Provider Name: Youth Opportunity Investments, LLC.
Location: Okaloosa County / Circuit 1
Review Date(s): March 10-13, 2020

MQI Program Code: 1440
Contract Number: 10210
Number of Beds: 30
Lead Reviewer Code: 144

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

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Crestview Youth Academy (Secure) program is a thirty-bed program, for thirteen to twenty-one-year old males, located in Crestview, Florida. The program is operated by Youth Opportunity Investments, LLC., through a contract with the Department. The program provides Substance Abuse Treatment Overlay Services (SAOS). The program is shared with Crestview Youth Academy (Non-Secure) program, which is located within the same building and under the same provider. Delinquency intervention services provided include Life Skills Training and Impact of Crime (IOC). The program also provides gender-specific programming, which includes, Male Healthy Relationships and the Teen Relationship workbook. The program provides SAOS groups for each youth and facilitates the Seven Challenges curriculum. For those youth who have a dual diagnosis, the program offers Skillstreaming the Adolescent curriculum. Program administration is comprised of a facility administrator and two assistant facility administrators. The program has one clinical director, one health services manager, three registered nurses, three case managers, and two mental health counselors. The program has a contract with a medical doctor (MD) and psychiatrist. The program also has one transitional case manager and recreational therapist, which are shared positions for both the non-secure and secure programs. Educational services are provided through an agreement with the Okaloosa County School Board. Teachers are employed through the school district and provide classes Monday through Friday. The layout of the program includes: one building which contains two dormitories, kitchen and cafeteria, education classrooms, medical unit, and case management, therapists, and administrative offices. The program has a total of seventy-one security cameras, of which all are operational, providing coverage, and have the ability to record and save video footage for up to thirty days. At the time of the annual compliance review, the facility administrator reported the following vacancies: six youth care workers, one shift supervisor, and one mental health counselor.

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.	

A total of four personnel records were reviewed for initial background screening requirements. Each staff had evidence of a background screening completed prior to their initial hire date. The background screenings conducted include a review of the criminal history report information. There was no indication of any staff having had a break in service. None of the completed background screenings indicate the staff were ineligible for hire. In each of the staff records reviewed, the provider had added the employees to the Clearinghouse employment roster. All four records reviewed were applicable for requiring a pre-employee assessment tool. In each of these records, the staff had a pre-employment assessment completed and passing score documented within their personnel record. The program reported having no volunteers or contracted staff who required an initial background screening for this annual compliance review period. The program submitted an Annual Affidavit of Compliance with Level Two Screening Standards to the Background Screening Unit (BSU) January 9, 2020. Teachers employed at the program are paid through an agreement with the local school board and Department of Education. Annual screenings are completed through an Annual Affidavit of Compliance with Level Two Screening Standards to the BSU by the Okaloosa County School Board on January 9, 2020. The program's written policy and procedures document practices to confirm the hiring authority reviewed Central Communications Center (CCC) person involvement history, Staff Verification System (SVS) module, and Florida Department of Law Enforcement (FDLE) results. The program has a human resources/business manager and is the person primarily responsible for putting together the necessary paperwork for completion of staff background screenings.

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.).	

A review of the program's employee/volunteer rosters revealed there were no staff, volunteers, mentors, and/or interns, who required a five-year background rescreening, since the last annual compliance review.

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

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

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

The program had a total of eight Central Communication Center (CCC) calls since the last annual compliance review. There was only one out of the eight which was allegedly related to physical, psychological, or emotional abuse. The one applicable CCC incident reviewed had recently occurred at the program in February 2020. No official findings for this incident have been documented within the CCC system related to physical, psychological, or emotional abuse. The program did, however, due to review of video and Protection Action Report (PAR), determine the staff in question used excessive force. Supporting documentation and video concerning the incident was provided to the residential operations staff for review. Staff personnel records were reviewed for adherence to the program's code of conduct. The reviewed staff personnel records contained a signed copy of the code of conduct. During a tour of the program, observations found the numbers to the CCC and the Florida Abuse Hotline were posted accessible to staff and youth. The program's written policy and procedures addresses incident reporting requirements and child abuse reporting practices. The Florida Abuse Hotline phone numbers and the number for the CCC shall be posted throughout the program, ensuring they are visible and readily available to staff, volunteers, and visitors. Staff shall provide unhindered access to report alleged abuse. Staff shall provide telephone access to report allegations of abuse. At no time should youth be prevented from self-reporting or making a call to the Florida Abuse Hotline or the CCC. Youth in controlled observation shall not be denied from making an abuse call; however, the call may be delayed until the youth demonstrates calm and complaint behavior. Staff shall document all requests and reasons for temporary delay. The shift supervisor must be notified immediately of youth's request to contact the CCC or Florida Abuse Hotline. The shift supervisor shall immediately attempt to notify the facility administrator or assistant facility administrator of the placement of an abuse call. Staff will assist youth in placing an abuse call. Staff will make the call, documenting the date and time of call, obtain the operator name, and document on the all information internal incident report. Staff will maintain sight contact of the youth but remain in an area which allows for the youth to freely and

confidentially report. In the event a youth changes their mind and no longer wants to make the call, then staff will document the youth's refusal of the call in the facility logbook and on the internal incident report. If the youth decides not to make the call, however, staff knows or has reasonable suspicion the youth has been abused or neglected, the staff will make an abuse report to the Florida Abuse Hotline or CCC, whichever is appropriate. The program environment appears to be free of physical, psychological, and emotional abuse. The program completed a Trauma Responsive and Caring Environment (TRACE) Self Assessment October 2, 2019. The program had one alleged incident related to physical, psychological, and or emotional abuse since last annual compliance review. Interviews were conducted with five youth. Each of the youth stated they felt safe at the program. None of the youth reported ever being prevented from reporting abuse to the Florida Abuse Hotline or CCC (if eighteen years or older), since they have been at the program. All five-youth stated, staff are respectful while talking with them and other youth. Each youth was asked if they had ever heard staff use curse words when speaking with them or other youth and how often. Four youth replied, never and one youth stated occasionally. The one youth further explained, staff occasionally use profanity by mistake. Interviews were conducted with five staff. Staff were able to convey the process for allowing staff and youth to call the Florida Abuse Hotline or CCC, for suspected abuse. All staff stated they have never observed a co-worker tell a youth they could not contact the Florida Abuse Hotline. Three out of the five staff stated they have never observed a co-worker using profanity, using threats, intimidation, or humiliation when interacting with youth. The two staff who replied yes, said some staff use profanity and are just playing around. Findings of youth and staff interviews were shared with program administration. An interview with the facility administrator confirms the program's incident reporting process is to contact an administrator as soon as possible with details of the incident. The vice president of Florida operations is notified of the incident. Administration will then determine if the incident is reportable based on Florida Administrative Rule. A call is required to be placed within two hours of gaining knowledge of the incident.

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 had eight Central Communications Center (CCC) calls since the last annual compliance review. There was only one out of the eight which was allegedly related to physical, psychological, or emotional abuse. The one applicable CCC incident recently occurred at the program in February 2020. No findings have been reported or found related to physical, psychological, or emotional abuse. No official findings for this incident have been documented within the CCC system related to physical, psychological, or emotional abuse. The program did, however, due to review of video and Protection Action Report (PAR), determine the staff in question used excessive force. The action taken by the provider in this case, supports management takes immediate action to address alleged incidents of physical, psychological, and emotional abuse. An interview with the facility administrator (FA) was conducted to determine how the program ensures staff and youth are knowledgeable in contacting the Florida Abuse Hotline and CCC and how does the program incorporate the results into management meetings. The FA reports the program conducts daily morning meetings to discuss any CCC and/or Abuse calls within the program for the management team. In addition, the program conducts monthly all team meetings to discuss all CCC and Florida Abuse Hotline information. Youth are reminded in weekly Townhouse Meetings of the process for contacting the Florida

Abuse Hotline or the CCC. The program has postings explaining the process for CCC and Florida Abuse Hotline reporting accessible to staff, youth, and volunteers. The FA reports there has been one staff with disciplinary actions due to allegations of abuse towards a youth since the last annual compliance review.

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

The program had four Central Communications Center (CCC) calls during the scope of the annual compliance review. All four CCC reports were reviewed. In three out of the four reports reviewed, the CCC was notified within two hours of the program becoming aware of the incident. The fourth CCC was found and reported around seventeen days later, after the initial incident due to video review by the facility administrator. Only one of the CCC's were applicable and was found documented in program's logbook. There were no indications of any internal incident reports and or grievances which should have been reported to the CCC. The program has not seen an increase or decrease in the number of reportable incidents to the CCC; the total number of incidents has remained the same. The facility administrator (FA) was asked to explain the program's incident reporting process. The FA confirms the program's incident reporting process is to contact an administrator as soon as possible with details of the incident. The vice president of Florida operations for the program is notified of the incident. Administration will then determine if the incident is reportable based on Florida Administrative Rule. A call is required to be placed within two hours of gaining knowledge.

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 had a total of eight Protection Action Reports (PAR) interventions during the scope of the annual compliance review. A sample of five PAR reports were reviewed. All five of the PAR intervention reports were completed by the end of the staff member's workday. Each of the five PAR reports included statements from all staff involved. None of the PAR interventions reviewed required the use of mechanical restraints. None of the PAR interventions resulted in any injury to a youth or staff. None of the PAR interventions documented any allegations of abuse made by youth or staff. Each of the PAR reports had a review completed by a PAR certified instructor or supervisory staff. None of the reports indicated a PAR medical review was necessary. Each of the reports indicated a Post-PAR interview was conducted with the youth by the administrator, or designee, as soon as possible, but no longer than thirty-minutes after the incident. Each of the PAR reports were reviewed by the administrator, or designee, within seventy-two hours of the reported incident, excluding weekends and holidays. A copy of the PAR reports were placed in the program's centralized file within forty-eight hours of being signed by the administrator. The program has submitted a monthly summary of all PAR incidents to the Department by the fifteenth of each month, for the past six months. The program's PAR plan was approved by the Department. The program has had an increase in the

total number of PAR incidents since the last annual compliance review. A discussion with the facility administrator (FA) revealed the increase is attributed to staff turnover and youth population changes; having received some youth from other programs which were closed. The FA feels now with stability in staffing and environmental culture adjustments, the number of PAR incidents will decrease. As evident by the total number of PAR incidents which have occurred, the program overall remains low in comparison to the statewide average. The program's PAR rate during the annual compliance review period was 1.42, which is below the statewide residential PAR rate of 2.41. The FA was asked to explain the process for monitoring PAR incidents and use of force, he replied: the program monitors PAR incidents and use of force by discussing with staff through monthly all team meetings, shift debriefing, and as needed coaching sessions. If there is a youth who is consistently involved in physical intervention, then program administration provides feedback.

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.	

A total of five staff training records were reviewed for pre-service training requirements. A review of five records found three staff had over the 120 minimum hours required of pre-service training. The remaining two staff were still completing training requirements and were within their 180 days of hire. All staff reviewed had received training in Cardiopulmonary Resuscitation (CPR)/First Aid/automated external defibrillator (AED) Professionalism and Ethics, including standards of conduct, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA). The program is part of the pilot project for the Department's Right Interactions: Youth Engagement Model (YEM). Four out of the five staff reviewed have successfully completed all requirements for certification. The fifth staff completed the physical component of YEM; however, has not been able to pass the written examination with a seventy-five percent or better. A review of the provider's contractual agreement revealed additional required trainings outlined for pre-service requirements. Each of the five records reviewed found the staff all received these additional trainings. Four out of the five staff reviewed, had all their respective training requirements documented within the Department's Learning Management System (SkillPro). The fifth staff member was missing a passing score for the YEM examination. All instructors were qualified to deliver training provided. The program submitted in writing a list of pre-service training to the Department's Office of Staff Development and Training on January 10, 2020, which included course names, descriptions, objectives, and training hours for any instructor-led training required.

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.*	

A total of five staff training records, which included two supervisory staff, were selected to review in-service training completed for the 2019 calendar year. All records reviewed contained over the twenty-four hours of annual training required. Each record contained evidence the staff had been in receipt of in-service training for Cardiopulmonary Resuscitation (CPR)/First

Aid/automated external defibrillator (AED), Protective Action Response (PAR) eight-hour refresher training, professionalism and ethics, including standards of conduct, and suicide prevention, which included four hours of instructor-led training and two hours of training completed within the Department's Learning Management System (SkillPro). A review of the provider's contractual agreement found no additional in-service trainings were required for the sample selected. For the two supervisory staff selected, each record had documentation of receiving the additional eight hours of required supervisor training in areas related to management, leadership, personal accountability, employee relations, communication skills, and fiscal training. All in-service training reviewed was documented within SkillPro as required. All instructors were qualified to deliver the provided training. The program submitted in writing a list of in-service training to the Department's Office of Staff Development and Training on January 10, 2020, which included course names, descriptions, objectives, and training hours for any instructor-led training required. The program had an annual in-service training calendar, which is updated as changes occur. An interview with the program staff revealed only staff who received training in PAR may supervise youth. This may include as needed; direct care staff, supervisors, case managers, master control operator, unit manager, assistant facility administrator, maintenance, and facility administrator.

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 written policy and procedures, which includes training requirements for the grievance process. A review of a ten staff training records, found nine have received required training on the program's grievance process and procedures. The program's grievance process includes at a minimum the following phases: informal, formal, and appeal. The informal phase is when concerns arise, youth shall be encouraged to make all efforts to reach resolution of issues and complaints immediately and directly through informal communication with the program staff involved. Youth may present an informal grievance with any staff member. All staff shall make every reasonable effort to discuss the youth's concern or compliant and assist the youth in resolving the issue. The program does not discourage youth from filing a grievance, if the youth chooses to do so. During the formal phase, grievance forms are available to all youth and are located in housing areas for youth to complete at any time during their stay. Youth may request instructions or request the assistance of staff, family, peers, or other advocates if needed to complete and submit a grievance form. All completed grievances shall be submitted into a designated grievance box which is secured and located in a central area for youth access. The grievance officer is responsible for collecting grievance forms daily. Any grievance received which alleges youth is substantially at risk for imminent sexual abuse or danger, shall be immediately reported to the facility administrator for immediate response. Assigned grievances will be reviewed and investigated by the assigned staff member within two days of the assignment. If the grievance is not resolved at the formal phase, a supervisor staff will investigate the grievance and respond within two days. The person investigating the grievance will never by the subject of the youth's grievance. Efforts will be made to conclude the grievance process within five working days. Grievance documentation will be filed and maintained in a grievance log for a minimum of twelve months. During the appeal phase, the grievance may be appealed to the facility administrator if satisfaction in not obtained at the formal phase. The program had a total of two grievances within the last twelve months. Each of the reviewed

grievances identified the nature of the issue. Each of the grievances were resolved at the formal phase and were completed the same date the youth submitted the grievance. Five youth were interviewed and were able to explain the program's grievance process. Each youth reported they can ask for assistance when completing a grievance form. Interviews with five staff reported all were able to provide information pertaining to process for assisting youth in handling a grievance. The facility administrator (FA) was interviewed and asked to explain the program's grievance process. The FA reports all staff receive pre-service training on the program's grievance process procedures.

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 has nine staff who are regularly assigned job duties to include the implementation of an intervention. Each of the staff reviewed have been in receipt of training for specific delinquency intervention model and effective implementation. Training reviewed for each staff noted the staff's date of training and their specific level of education. The staff members reviewed, had a number of years of experience working with adult and or juvenile offenders. The program management considers the education and work experience when determining staff delivery of delinquency intervention services. A review of the provider's contractual agreement revealed the required delinquency intervention services are Life Skills Training and Impact of Crime (IOC). In addition, the program provides Male Healthy Relationships: Young Men's Work, Seven Challenges, and Skill streaming the Adolescent. Each of the contractually required interventions are an evidenced-based intervention, with the exception of the IOC curriculum, which is a promising practice. A review of the program's activity schedule determined the program provides structured, planned programming or activities at least sixty-percent of the youths' awake hours. A review of group sign-in sheets for each of the program's contracted delinquency interventions were reviewed. Groups are being delivered as indicated on the program's activity schedule. A review of five staff training records was conducted, each received training on the program's evidenced based strategies. Five youth were reviewed for involvement in a delinquency intervention which is evidence-based, promising practice, a practice with demonstrated effectiveness, and any other intervention approved by the Department. At the time of the annual compliance review, each of the youth reviewed were participating in Seven Challenges. The youth were involved in a delinquency intervention addressing an identified priority need. The youth's performance plan addressed an identified priority need. The facility administrator (FA) was asked to explain how a staff members education and work experience were considered when determining which staff would deliver life skills trainings/groups. The FA reports therapist and case managers who have credentials are the individuals selected to facilitate these groups with the youth. In addition, youth are assigned to therapists based on their individualized treatment. For example, an acute youth will be assigned to a more experienced counselor and/or in some cases a licensed therapists. Intervention groups are assigned based on the youth's diagnosis. The program's designated mental health clinical authority (DMHCA) also provided, substance abuse services are provided to the youth through the Seven Challenges curriculum in group and individual therapy sessions. Training on the curriculum is provided by a master trainer who has attended a Seven Challenges Leader

training. Fidelity monitoring of the groups are provided monthly to each therapist and youth journals are reviewed periodically for therapist fidelity.

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

The program provides Life Skills Training (LST). Youth are provided with life and social skill intervention services, as outlined within the LST curriculum, which specifically address, at a minimum: communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking skills. The program's process to determine how services are provided is youth's needs are assessed at intake during their comprehensive evaluation by a therapist. Based off the youth's individual assessment, life and social skills curriculum will be provided. A review of the program's activity schedule demonstrates the youth are in receipt of life skills education, training, and groups as required. A review of group sign-in sheets of the programs LST curriculum delivery, determined the life and social skills are being conducted according to the program's group/activity schedule. The clinical director was interviewed and asked to explain their role in the coordination of services at the program. The clinical director reports they provide and oversee the implementation of mental health and substance abuse services through group and individual therapy. In addition, the clinical director creates the group schedule and ensures it is adhered to daily, as well as tracking individual therapy sessions which are conducted by the master's-level therapists. When a youth is admitted to the program, the clinical director determines the appropriate therapist for each youth based on the youth's needs and the therapist's background, level of experience, and approach. Five youth were interviewed and to determine what groups they participate in and what is learned during groups. Each of the five youth were able to identify groups they were participating in and what was learned while participating. Each of the youth also described some of the new skills or behaviors they had been taught while in groups.

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 provider's contract requires the implementation of the Impact of Crime (IOC) Curriculum. These guiding principles within the IOC curriculum provide restorative justice awareness and activities. The restorative justice activities are designed to assist youth to accept responsibility for harm they have caused by their past criminal behaviors, teaches them about the impact their crimes have on victims, families and their communities, and provides for youth various opportunities to participate in reparation activities such as restitution and community service projects. In addition, expose youth to victim perspectives through victim speakers, in person or on videotape or audiotape, or through victim impact statements. This practice engages youth in follow-up activities to process their reactions to each victim's accounting of how crime affected their life. A review of staff training records revealed staff had been in receipt of training for restorative justice awareness. A review of the program's activity schedule, group sign-in and out sheets, and curriculum materials revealed the IOC groups were being conducted as scheduled. The facility administrator explained the program's role in facilitating activities around restorative justice. The IOC course is conducted, Tuesday and Thursday for an hour each day. Youth have

assisted LifePoint Church with setting up for their Easter celebration. Youth have cleaned the stadium following several football games for Crestview High School. Youth stripped, waxed, and moved furniture during the summer. Youth helped renovate the doctor's office by painting the office. Youth provided a free carwash for the community and bought school supplies with the donations and provided those to youth in need for school. Youth have also assisted the elderly in the local nursing home. Youth are exposed to victims through community service, restorative justice projects, and/or guest speakers. A sample of five youth records was reviewed and found each youth was receiving the IOC groups as required.

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.	

Based on the provider's contractual agreement, the program provides the following curriculums to address gender responsive services: Male Healthy Relationships: Young Men's Work. The curriculum is designed to address the targeted needs of the program's all-male population. A review of worksheets, handouts, and youth signature sheets was conducted and determined groups for gender-specific programming is being delivered according to program's activity schedule. According to the facility administrator, the program addresses the needs of their specific male population, as youth are provided the Young Men's Work and also healthcare education.

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's written policy and procedures addressed how alerts are identified, documented, updated, and communicated to staff. The program's alerts were observed to be consistent with the alerts which were entered into the Department's Juvenile Justice Information System (JJIS). A check was conducted with each of the team members who were reviewing case management, medical, mental health, and safety and security for youth's with identified alert risks with no issues. A total of five youth was reviewed for consistency between the program's internal alerts and alerts entered JJIS with no issues observed. Youth who may have had an identified alert type, were appropriately removed or downgraded by appropriate staff. In addition, when applicable, there was documentation within the program's logbook, where a youth's alert was identified and communicated to staff. There was a corresponding JJIS alert start and end dates when necessary. Each of the alerts were verified prior to entering into JJIS. Each of the alerts matched in JJIS and the program's internal alert system.

A total of five staff were interviewed on how each are informed of the youth's alerts including mental health, medical, and security. Staff responses provided a view into the practices of how the program communicates youth alerts to staff. Staff stated there is an alert board, sign-in logbook, shift debriefing, and updates provided for by both the mental health and medical departments. The facility administrator (FA) was interviewed addressing the program's practice for communicating alerts. The FA reports morning management meetings are held Monday through Friday with the nursing staff to distribute an alert list each day. Each department head is responsible for input and closing any information into JJIS. The alert board is located in the conference room. Management team reviews alerts daily or as information changes.

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 separates the youth records for healthcare, mental health, and case management. The youth records included a file tab for the youth's name, Department of Juvenile Justice identification number, date of birth, county of residence, and committing offense. The youths' record contained the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous section. All youth records were observed to be labeled "Confidential". All official youth case records are secured in a locked file cabinet or a locked room as observed while on-site during the annual compliance review. The program clearly identifies any file cabinet used to store official youth case records as "Confidential".

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

The program has a formal process to promote constructive input by youth. The program solicits input from youth through weekly meetings, monthly student council meetings, through request to speak forms, and through monthly surveys. The youth housing meetings provide youth opportunities to address and offer input into daily programmatic concerns or issues as needed. A review of agenda's, sign-in sheets, minutes, and surveys, supports the program's efforts to solicit input from the youth. A total of five youth were interviewed; each confirmed they have a process to provide input about what happens at the program through the student council meetings. The facility administrator (FA) was interviewed concerning process to solicit youth input at the program. The FA reports youth can use request to speak forms, weekly meetings, advisory board meetings, and day to day interaction with the youth.

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

The program has a community advisory board which meets at least every ninety to 120 days. Observation of sign-in sheets, agendas, and minutes from the advisory board meetings was conducted and revealed the program meets at a minimum every ninety days. The advisory

board consist of community members from the judiciary, business, and other community partners. The program was unable to provide any supporting documentation of where the facility administrator solicited/recruited involvement from parent/guardian whose child was previously involved in the juvenile justice system having been recruited and a person from the lesbian, gay, bisexual, transgender, and intersex (LGBTI) community. The facility administrator was interviewed and stated, our community advisory board meeting is completed quarterly. The time varies based on the members schedules. The community advisory board provides suggestions and ways of how to assist the program and youth while in and out of the program. An interview with an advisory board member was conducted. The board member was able to articulate involvement with the program and activities the board discusses quarterly for the youth.

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

Reviewed a sample of youth and parent/guardian surveys for program planning. Surveys observed solicit input from youth and parent/guardian related to the program planning. The Comprehensive Accountability Report (CAR) is a published report related to the program, which is generated by the Department of Juvenile Justice annually. In addition, the monitor and quality improvement annual compliance reports are posted for review. The program shares with staff, beginning with the vice president of operations, through staff meetings concerning program planning. Meeting minutes reflect areas discussed from surveys and reports generated for program planning purposes. A review of sign-in sheets demonstrated staff appear to be in attendance to all staff meetings at a minimum monthly. The facility administrator ensures provisions for staffing, to include at a minimum a system of communication to keep staff informed and give opportunities to provide input and feedback pertaining to operation of the program. In addition, staff retention planning including steps to minimize turnover and improve employee morale, which is addressed in the program's written policy and procedures. The actual practice taken to minimize staff turnover is the program's internal incentive program, which enables each staff opportunities to earn rewards. Program management recognize staff for job performance and are given a reward chip. The reward chip can then be redeemed towards incentive items such as, shirts, jackets, and gift cards. A review of the program's written policy and procedures determined the program has a system of staff communication, opportunities for providing input, and feedback on the program's operations. Observed staff meeting minutes and agendas which demonstrated staff have opportunities to discuss program planning initiatives. Observed sign-in sheets for staff meetings, staff appear to be in attendance to staff meetings held monthly. In addition, supervisor meeting is conducted bi-monthly and direct care staff participate in daily debriefings. Also, treatment team meetings are held with clinical staff daily. Five staff were interviewed and asked how often staff meetings are held; all staff responded monthly. Staff report topics discussed during meetings cover dress code, guidelines, youth ideas, policies, alerts, suicide risk, cleaning, and youth intake/releases. Some staff were not fully aware if they are briefed on any annual reports or youth and parent/guardian survey results. Staff believe communication at the program, ranges from very good to fair. Staff report, they are able to provide input and feedback into program operations. The facility administrator (FA) states in the way of staff turnover, overall competition in the area is a challenge. There are different providers which have competitive salaries to recruit staff. The FA reports staff turnover is a challenge; however, with increased morale functions such as cookouts, potlucks, movies, bowling, meals provided by management, staff acknowledgements, and awards have helped with staff retention. The program has provided salary increases for those who receive outstanding evaluations. In addition, staff promotions from within have helped with staff retention. The FA reports the program utilizes exit parent/guardian surveys, family

sessions, individual sessions, and treatment team for program planning purposes. Information from reports comes from the vice president of Florida operations, who shares the information with the facility administrators and the information is shared with the remainder of the team during morning meetings and daily debriefings.

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 written policy and procedure to determine the system for evaluating staff, performance standards, and frequency of evaluations. The program's written policy identifies at a minimum staff will be evaluated at least annually. An observation of position descriptions demonstrated staff member's performance standards are clearly identified. Performance evaluations reviewed demonstrated they are completed as outlined within the program's written policy and at a minimum annually. Staff are evaluated annually on established performance standards. The observed performance standards matched job descriptions for each staff. Key personnel as outlined within the program's contract are being maintained and performed as outlined. The facility administrator was interviewed and provided the following to explain the annual evaluation process for staff; all staff are provided performance evaluations. Five staff were interviewed and asked the frequency for receiving a formal evaluation of their performance. Four out of five staff reported yearly. The fifth staff replied other stated they have been given one performance evaluation.

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 for a variety of recreation and leisure type activities. The activity schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth. A review of the logbook demonstrates the activities are documented according to the program's activity schedule. The program has written policy and procedures which provide activities based on the developmental levels and needs of the youth in the program. Activities include a choice of leisure and recreation options. Activities offered provide for options to explore youth's interest. Youth were observed throughout the annual compliance review time on-site engaged in constructive use of leisure time, indoor and outdoor type activities. Activities promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program takes precautionary measures to prevent over-exertion, heat stress, dehydration, frostbite, hypothermia, and exacerbation of existing illness or physical injury. A water cooler was observed available for youth while outdoors during recreation. The program contract includes a recreational therapist position. A review of the program's staffing roster as well as the therapist's credentials, schedule, the provider's contract, and services provided to youth demonstrate all requirements are being met. A review five youth demonstrated the therapeutic activities provided for are a part of each youth's performance and/or treatment plan. The program has a formal process to promote constructive input by youth. Five youth were interviewed, each of the youth agreed there are physical activities and leisure activities provided for at least one hour. Youth described some of the activities; football, basketball, dodgeball, kickball, and running at least one hour each day. The youth also confirmed they are provided with varying degree of mental and physical exertion throughout the day. Five staff were interviewed, each were able to

provide an example of what types of indoor and outdoor activities, along with duration of time involved which are provided to the youth.

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.	

Five case management records were reviewed to verify initial contact with a parent/guardian by phone within twenty-four hours of admission. In all cases, staff mailed a letter to parents within forty-eight hours. All five cases showed telephone contact on the day of admission. Staff also sent letters within five working days to the juvenile probation officer (JPO) notifying them each youth was admitted to the program.

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

Five case management records were reviewed for orientation requirements. Documentation revealed the program provided an orientation packet to each of the five youth upon admission. The orientation included information pertaining to services available, a daily schedule, program expectations, the program's written behavioral management system, access to mental health and medical services, access to the Florida Abuse Hotline, a list of items considered contraband, the performance planning and treatment team process, procedures for correspondence with family, dress code and hygiene practices, community access, grievance process, and emergency procedures. A youth admission was not observed during this annual compliance review. Orientation included all elements as outlined within the program's written policy. Five youth were interviewed, each youth confirmed they began orientation within twenty-four hours of admission.

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.	

Three case management records were applicable for review of written consent of a youth eighteen years or older. The three case management records contained documentation of each youth's written consent, prior to any release of information.

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

Five case management records were reviewed for classification factors, procedures, and reassessment for activities. Staff administered assessments on the day of admission to determine the appropriate classification for each of the youth. The initial classification factors included, physical characteristics, age, maturity, special needs, history of violence, gang affiliation, escape risk, suicide risk, and security risk. Each of the five records also contained a completed Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening instrument to determine suitable placement in living units. A review of the Juvenile Justice Information System (JJIS) revealed no issues affecting classification. Reassessments were completed in each of the five youth case management records. Reassessments were completed to increase the youth's privileges or freedom of movement, participation in work projects or other activities involving tools, and for participation in off-campus activities.
An interview with the facility administrator was conducted and asked to explain factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning youth to a living unit. He stated, treatment team conducts a classification meeting, with a minimum includes the director, assistant facility administrator, clinical director, assistant clinical director, case manager, nurse, and/or parent/guardian by telephone. This classification is designed to gather the information mentioned above as well as any gang involvement. The information is shared with the administration and the decision regarding the MOD and room assigned. The room assigned can be based on VSAB results. At some point during a youth's stay it is possible the room can change. The program has a written policy and procedures which clearly outlines the classification process and includes a classification system which promotes safety and security, as well as effective delivery of treatment services. In addition, the written policy addresses when a reassessment is warranted based upon changes in the youth's supervision status, new/updated alerts, relevant information available to the treatment team, and/or behavioral concerns. A review of the program's internal alerts system was conducted. Program staff are made aware of youth who are a security and safety risk, escape risk, suicide or other mental health risk, medical risk, sexual predator risk, or other violent behavior risk.

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.	

Five case management records were reviewed for notification to law enforcement regarding gang identification for youth admitted to the program. The program had only two examples of youth who were identified as gang members during the annual compliance review period. Staff completed a gang assessment as part of the orientation into the program at the time of admission. The gang liaison presented a binder which contained documentation notification was

made to the appropriate law enforcement agencies. There was evidence contained within the Department's Juvenile Justice Information System (JJIS), where gang alerts had been added for each youth reviewed. Information on each of the youth's gang status was shared with the educational provider. In addition, information was shared with the youth's juvenile probation officer (JPO) and post-residential counselor.

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.	

Five case management records were reviewed to assess if the program is providing intervention strategies to youth identified as gang affiliated, members of a criminal street gang, or youth who are identified as high risk to be involved in gang activity. The program had only two examples of youth who were identified as either gang members or affiliated with gang activity during the annual compliance review period. Each of the youth participated in gang prevention and intervention strategies. Both youth's performance plans included relevant goals and objectives related to gang intervention strategies. The program utilizes Impact of Crime (IOC) curriculum as an intervention strategy for addressing relevant gang issues. The program has a written policy and procedure which allows for a youth an opportunity, if they desire, to develop a plan to dis-affiliate with criminal street gangs.

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.	

Five case management records were reviewed regarding Residential Assessments for Youth (RAY) and reassessments. Each of the records reviewed show the RAY was conducted within the thirty-days of the youth's admission. Each of the initial assessments were maintained in the Department's Juvenile Justice Information System (JJIS). Four of the five youth reviewed were eligible for ninety-day reassessments since one youth had not been at the program longer than ninety-days. All four of the eligible records also reflected reassessments were completed within the ninety-day timeframe or as needed when interventions were needed prior to the ninety-days. The program maintained all reassessment documentation in the youth's official case record.

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

Five case management records were reviewed to determine if a Youth Needs Assessment Summary (YNAS) was completed within thirty days of admission to the program. Each of the records reviewed contained a completed YNAS within thirty-days of the youth's admission to the program. The YNAS was documented in the Department's Juvenile Justice Information System (JJIS) as required for each of the records reviewed.

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.*	

Five case management records reviewed contained an Individual Performance Plan (IPP), which was developed within the first thirty days of each youth's admission. Each of the IPPs reviewed were developed after the initial assessment was completed. The intervention and treatment team present during the development of the IPP, included a treatment leader, youth, an administrative representative, living unit representative, treatment staff, and education staff. Two out of the five records reviewed were applicable for inclusion of a representative from the Department of Children and Families (DCF) in the development of the youth's IPP. Each of the performance plans were signed by the youth, treatment team leader, other relevant persons responsible for goal completion, and parent/guardian. Each of the performance plans contained goals which were individualized based upon the prioritized needs reflecting the risk and protective factors identified in the initial assessment process. Each of the five plans addressed the top three criminogenic needs. In addition, the records contained specific delinquency interventions, with measurable outcomes. The performance plans included target court ordered sanctions, along with transition activities targeted for the last sixty days of the youth's anticipated stay. The performance plans also included the youth's responsibilities to accomplish individualized goals, along with program staff accountability to assist the youth in completing established goals. Each goal identified, had a target date established for completion. A copy of the completed plan was provided within ten working days to the parent/guardian, youth, juvenile probation officer (JPO), applicable DCF counselor, and the committing court. Five youth were interviewed, each was able to explain the program's treatment process, which included the development of the youth's performance plan, treatment team meeting, and goals working towards. All five youth stated they have a copy of their 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.	

Five case management records were reviewed, four were applicable for revisions to the youth's Individual Performance Plan (IPP). Revisions for the youth reviewed, may have been completed for Residential Assessment for Youth (RAY) changes, newly acquired information, demonstrated progress in completing a goal, and or demonstrated lack of progress toward a completing a goal. Two out of the five records reviewed were applicable for revision to the youth's IPP as a result of the need to facilitate transition activities during the last sixty days of the youth's stay.

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.*	

Two of the original five case management records were applicable for review of performance summaries and transmittals. One additional closed record was reviewed to make a minimum sample of three records reviewed. Each of the three records contained a performance plan completed every ninety days following the signing of the performance plan. Each of the summaries included information on the youth's status on the performance plan goal, overall treatment progress, academic status, youth's behavior, level of motivation/readiness to change, interaction with peers, interaction with staff, overall behavior adjustment to the program, significant positive and/or negative events, and justification for release, discharge, or transfer. Each of the performance transmittals contained documentation, the youth were provided an opportunity to make comments prior to signing. The youth was also provided with a copy of the summary. An original summary was filed in the youth's case management record. Each of the performance transmittals were signed and date by the required treatment team members and the youth. A copy of the summary was sent within ten working days to the youth's committing court, juvenile probation officer (JPO), youth, and parent/guardian. Three closed case management records were applicable for completion of a release summary. Each of the reviewed records contained an original summary, along with justification for release, which was sent with the Pre-Release Notification (PRN) to the JPO. In addition, the release summary and PRN was sent at least forty-five days prior to the youth's planned release. Each had a signed copy, which was retained in the youth's case management record. There was no indication where the court objected to any of the youth's release. In each of the reviewed records, the program provided written notification to the parent/guardian of the planned release. There was documentation to support the program completed an exit assessment for each of the youth. The program provided to each of the youth's JPO, a performance summary, transition plan, and when applicable any psychological/psychiatric report completed. All five interviewed youth indicated they received a copy of their performance summary.

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

Five records were reviewed for parent/guardian involvement in the case management service process. All five youth records showed participation in the assessment process, participation in the development of the youth's performance plan, progress reviews, formal treatment team meetings, and transition planning. Parents/guardians in all five cases were provided the opportunity to participate by phone/video if they were unable to attend in person after receiving written notice from the program about times and dates of treatment team meetings. The program reaches out to parents/guardians by phone, email, and letters to encourage participation in youth involvement while at the program. An interview with the facility administrator concluded the program sends invitations to parents/guardians and family members for treatment team, family days, and visitations. Four out of the five youth interviewed, confirm their parents/guardians are involved in their case management, treatment plans, and treatment teams. The fifth youth stated he is eighteen years of age and his parent/guardians are not involved in his treatment.

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

A review of five case management records confirmed treatment team members are comprised of a treatment team leader, youth, administrative representative, living unit representative, treatment staff, education staff, Department of Children and families (DCF), juvenile probation officer (JPO), parent/guardian, gang prevention specialist, transition services manager, and recreational therapist.

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.	

Each of the five case management records reviewed, included the incorporation of academic or treatment into their performance plan. Three out of the five records reviewed were applicable and contained separate treatment plans related to medical, mental health, or substance services. Two of the five case management records reviewed were applicable for requiring a behavior support plan through the Department of Children and Families (DCF) or Agency for Persons with Disabilities (APD).

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.	

Five case management records were reviewed for documentation of the treatment team meetings. Each of the records contained documentation the treatment team occurred in a formal capacity every thirty days. Formal performance reviews were documented in the youth record and contained the youth's name, date of review, comments by treatment team members, brief synopsis of youth's progress, performance plan revisions, and progress on performance goals. In addition, formal performance reviews documented, positive and negative behaviors, treatment progress, reassessment results, and input from the youth to demonstrate skills acquired in the program. The programs informal reviews were found in four out of the five case management records reviewed. The fifth case management record was missing an informal review. Each of the informal performance reviews were documented in the youth's case management and contained the youth's name, date of review, meeting attendees, comments from treatment team members, brief synopsis of youth's progress, performance plan revisions, and progress on performance goals. In addition, informal performance reviews documented, positive and negative behaviors, treatment progress, reassessment results, and input from the youth to demonstrate skills acquired in the program. A treatment team was observed during the annual compliance review. The treatment team included all required staff, to include statement from education staff prior to the meeting. The treatment team meeting documented the youth's progress on performance goals, positive and negative behaviors, treatment progress, and the youth's opportunity to demonstrate skills acquired in the program. A review of the Department's Juvenile Justice Information System (JJIS) anticipated release dates revealed JJIS is updated at a minimum every ninety days. Five youth were interviewed and stated staff review progress on performance plan goals, positive and negative behavior, and treatment progress during treatment team meetings. Each youth also indicated they are given the opportunity during treatment team meetings to demonstrate any skills they have learned while in the program.

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

Three closed case management records were reviewed for vocational competency development skills. The records contained sample completed employment application or documentation showing it was completed online. In addition, a résumé, documentation indicating location and business hours of a local Career Source center, and documents necessary to obtaining employment. Also, there was documentation to support the youth's parent/guardian and juvenile probation officer (JPO) are aware of the vocational plan for the youth. The program offers a vocational path, which is appropriate for the age of the youth in the program. The career education program is appropriate for the educational abilities and goals of the youth in the program. The program offers Type 3 vocational programming. The youth are administered the My Career Shines assessment. The program also addresses communication, interpersonal, and decision-making skills. All youth are offered the vocational study of Microsoft Office Suite. The youth can earn Career and Professional Education (CAPE) certifications in Microsoft Suite. The

interviews with the program director and lead educator confirmed the age appropriate vocational services.

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 integrates education instruction into their daily schedule. Youth participate for 240 of 250 days of instruction. Ten days are used for teacher training or planning. The youth earn credits if enrolled in high school courses. The youth attend twenty-five hours of instruction a week. A review of the logbook indicates the youth follow the daily bell schedule. One of five youth interview results indicate educational instruction was interrupted once when a teacher was not present in the class. The lead teacher interview did not indicate any interruptions of 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.	

A review of three closed youth case management records were reviewed, and each contained an education transition plan developed upon the youth's arrival date. Each plan was based upon the youth's post-release goals beginning at the youth's admission to the program, as required. Documentation indicated the parent/guardian was aware of the Education Transition Plan. The Electronic Educational Plan (EEP) is incorporated with the Education Transition Plan (ETP). The ETP has documentation of specified monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services.

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

A review of three closed youth case management records confirmed the program held a transition conference at least sixty-days prior to each youth's targeted release date. The following intervention and treatment team members participated in the youth's transition conference, youth, treatment team leader, program director (or designee) parent/guardian,

juvenile probation officer (JPO), parent/guardian, educational staff, and other pertinent parties. During a transition conference call, team members review transition activities on the youth's performance plan. In each of the records reviewed, the team did not review target dates for goal completion or persons responsible for completion. The treatment team leader does however, obtain attendees signatures representing their acknowledgement of the transition goals and accountability for completion. All three closed case management records contained documentation the Community Re-Entry Team (CRT) meeting was conducted prior to the youth's release. The CRT meeting included the youth and case manager participating. There was evidence, an email generated, as an invitation to participate in the CRT meetings for each of the three records.

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

A review of three closed case management records confirmed an exit portfolio was discussed and initiated for the youth at the transition conference. The following items were included in each of the youth's exit portfolio, state-issued identification card, copy of the transition plan, calendar with all upcoming community appointments, social security card, and birth certificate. In addition, educational and vocational certificates earned while in the program, educational records, school transcripts, résumé, and sample employment application, were included in each of the youth's exit portfolio. Reviewed documentation supported the youth's exit portfolio was verified at the youth's exit conference and sent to the youth's juvenile probation officer (JPO). Documentation supported the completed exit portfolio was provided to the youth upon their release.

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

Three youth case management records were reviewed to determine if all of the required elements for the exit conference were present. All three exit conferences took place within fourteen days of the youth being released from the program. There was documentation the transition activities were reviewed and finalized by the attendees which included the youth, treatment leader, education representative, juvenile probation officer (JPO), and parent/guardian.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor (LMHC), who serves as the designated mental health clinician authority (DMHCA). The LMHC is licensed under Chapter 491, Florida Statutes. A review of the LMHC's license was conducted, which revealed the license is clear and active, and expires March 31, 2021. The LMHC is a full-time employee of the program and is on-site forty hours a week to ensure appropriate coordination and implementation of mental health and substance abuse treatment services. A copy of the LMHC's licensure and position description were available for review while on-site. An interview was conducted with the DMHCA which confirmed her role at the program. The DMHCA reported all mental health and substance abuse services are provided by or under the direct supervision of the DMHCA who is responsible for the oversite and the delivery of all treatment related services at the program.

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

The program does not have any other licensed clinical staff other than the designated mental health clinician authority; therefore, this indicator rates as non-applicable.

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

The clinical supervisor assures each of the four non-licensed clinical staff are performing services each of them are qualified to provide based on education, training, and experience. All four non-licensed clinical staff hold the appropriate level of education necessary and are in accordance with the contract between the provider, the Department, and Florida Administrative Rule 63N-1. Each of the three non-licensed clinical staff hold master's-level degrees from an accredited university, one in social work and two in counseling and psychology. The clinical

supervisor conducts weekly on-site, face-to-face direct supervision by the licensed clinical supervisor in a group format for the purpose of overseeing and directing the mental health services is provided at least one hour for each contact. All face-to-face supervisions occurred, as required. Each of the face-to-face supervisions conducted were recorded on a similar form to the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019), which included all necessary information. The program is licensed under Florida Statute Chapter 397, to provide substance abuse treatment services; certified by the Department of Children and Families (DCF). Two of the three non-licensed clinical staff received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Interview with the DMHCA confirmed the one non-licensed clinical staff switched from a direct care staff to non-licensed clinical staff in December 2019. The DMHCA reports no assessments have been conducted without direct supervision, until the twenty hours of training has been completed. The non-licensed clinical staff's training was documented on the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk (ASR) form (MHSA 022.) All non-licensed mental health and substance abuse clinical staff at the program providing services have received training in accordance with the Department's Rule 65D-30 Florida Administrative Code. Each non-licensed mental health clinical coordinator received twenty-hours of training in conducting ASRs, to include five ASRs or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and documented on the MHSA 022 form. One non-licensed clinical staff is a registered mental health counselor intern with an expiration date of March 8, 2023, which was provided and reviewed. The DMHCA is responsible for reviewing and signing comprehensive substance abuse evaluations, updated comprehensive substance abuse evaluations, initial substance abuse treatment plans, and individualized substance abuse treatment plans prepared by the clinical coordinators within ten calendar days. The DMHCA is responsible for reviewing each ASR and Follow-Up ASR, Crisis Assessment, and Follow-Up Crisis Assessment within twenty-four hours of the referral for assessment. The form must be signed by the DMHCA the next scheduled time on-site.

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.	

Five youth records were reviewed for a mental health and substance abuse admission screening. Each of the youth had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) completed upon admission. All available information was reviewed, to include the commitment packet, reports, and records from existing documentation of mental health and or substance abuse issues. The five MAYSI-2 screenings were completed on date of youth's admission to the program in a confidential manner. The MAYSI-2 screenings were administered in the Department's Juvenile Justice Information System (JJIS.) All five screenings were conducted by case management staff who completed the appropriate MAYSI-2 training within the Department's Learning Management System (SkillPro). Four of the five MAYSI-2 screenings indicated further assessment was required. Staff determined each of the youth assessed to have either a mental health need, substance abuse problem, and/or was a suicide risk. In each record, a referral for further evaluation was generated. All five youth received an Assessment of Suicide Risk (ASR) and were subsequently referred for assessment. All five ASRs were conducted within twenty-four hours of the referral. All five youth were referred for a

comprehensive evaluation, as required, with a reason for referral documented. The program has written Facility Operating Procedures (FOP), which were developed by the program director, addressing the implementation of a standardized admission and intake mental health and substance abuse screening process. The written FOPs included a standardized screening process which included the review of the commitment packet information, reports, records, and the administration of the MAYSI-2 in JJIS. Each screening administered is conducted by a "qualified professional," and a referral made for youth identified in need of further evaluation or immediate attention when necessary. The program's written FOP also identified standardized process for referral of youth identified as in need of further mental health and/or substance abuse evaluation to an appropriate service provider or professional, or when immediate attention is needed, to a hospital for Baker Act or Marchman Act. A review of five separate youth records demonstrated the program staff conducting screening, reviewed youth's commitment packet information, reports, and records for existing documentation of mental health and/or substance abuse problems, needs, or risk factors. Interview with the facility administrator states the MAYSI-2 and ASR assessments are the screening instruments used to identify at risk youth for mental health and substance abuse problems.

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.	

Five youth records were reviewed for a mental health and substance abuse assessments/evaluations. Each of the youth records reviewed had a new mental health evaluation completed within thirty calendar days of admission. All of the new mental health evaluations were conducted by a non-licensed mental health clinical staff, which were subsequently reviewed and signed within ten days by a licensed mental health professional. All of the new mental health evaluations conducted contained the youth's demographics, reason for evaluation, relevant background information, behavioral observations, mental status examination, discussion of findings, diagnostic impression, and recommendations for each youth. A total of five youth records reviewed for completion of a substance abuse assessment and each were completed. The substance abuse assessments were completed under the program's Chapter 397 license. Each of the five reviewed youth records contained a signed consent for substance abuse services from the youth. The substance abuse assessments were completed within thirty calendar days of admission to the program. The new substance abuse assessments contained a reason for assessment, relevant background information, behavioral observation, methods of assessment, patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, risk factors of continued alcohol and other drug abuse, clinical impression to include diagnoses from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-IV-TR), and recommendations. Each of the five new substance abuse assessments addressed the youth's original referral reason.

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.*	

Five youth records were reviewed for mental health and substance abuse treatment. Each of the youth records indicated the youth were assigned to a treatment team upon arrival to the program. The multidisciplinary treatment teams were comprised of the youth, program administration, staff from the residential living unit, and other staff responsible for delinquency intervention and treatment services for the youth. For each of the five records reviewed, treatment team documentation validated teams were comprised of representatives from administration, education, vocational training, medical staff, mental health staff, substance abuse staff, youth, and, when possible, the youth's parent/guardian. All five of the youth reviewed were determined to be in need of substance abuse treatment. The youth were in receipt of one or more of the following: individual, group, or family counseling, and/or psychiatric medication management. The substance abuse treatment at the program is provided by a licensed qualified professional or a non-licensed substance abuse clinical staff under the direct supervision of the licensed mental health counselor (LMHC). In addition, each of the five youth records reviewed were applicable for mental health treatment. The five youth reviewed each had a properly executed Authority for Evaluation and Treatment (AET) form contained within in their respective Individual Healthcare Record (IHCR). Each youth in receipt of services had documentation of a clinical impression to include a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) mental disorders. Each of the five youth records reviewed for substance abuse treatment contained a signed Substance Abuse Consent and Release form; forms were completed on the Department's Youth Consent for Substance Abuse Treatment (MHSA 012) and Youth Consent for Release of Substance Abuse Treatment Records (MHSA 013) forms. Mental health and/or substance abuse treatment notes were completed on the program's form, which contained all of the required information within the Department's Counseling/Therapy Progress Notes (MHSA 018) form. Interview with the designated mental health clinician authority (DMHCA) confirmed mental health treatment groups did not exceed ten participants and Substance Abuse Overlay Services (SAOS) treatment groups were limited to fifteen or fewer participants. Each of the five youth records contained documentation the youth were involved in individual psychotherapy or counseling. Youth were engaged in therapeutic activities designed specifically to address skill deficits or maladaptive behaviors. Substance abuse treatment was provided by a licensed qualified professional or a non-licensed substance abuse clinical staff. All five youth interviewed reported they are participating in groups and receiving specialized therapy. All five direct care staff interviewed reported they do not facilitate any mental health or substance abuse 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.*	

Five youth records were reviewed for youth treatment planning. All of the reviewed youth records contained an Initial Mental Health and Substance Abuse Treatment Plan. The Initial Mental Health and Substance Abuse Treatment Plan form included all of the information contained within the Department's Initial Mental Health/Substance Abuse Treatment Plan (MHSA 015) form. Each of the five youth records reviewed had an Initial Mental Health and Substance Abuse Treatment Plan developed within seven days of admission to the program. One record included an addendum to the initial treatment plan to include the youth's psychiatric services, seven days after the initial treatment plan was completed. All initial treatment plans were completed by a non-licensed mental health clinical staff and reviewed and signed by the licensed clinical supervisor within ten days of completion. Each of the initial treatment plans were signed by treatment team members who participated in the development of the plan. Three of the five youth were applicable for psychiatric needs upon admission. Two of the three initial treatment plans, included psychiatric needs, which also addressed medication and frequency of monitoring by the psychiatrist, and one record included psychiatric needs in the addendum seven days after admission. Each youth contained site-specific progress treatment notes, which were signed by mental health and substance abuse clinical staff and youth. Five youth records were reviewed for development of an individualized treatment plan and reviews. All of the youth records contained an individualized treatment plan, which was developed within thirty days of the youth's admission to the program. The five individualized treatment plans were developed the Department's Individualized Mental Health/Substance Abuse Treatment Plan (MHSA 016) form. Each of the individualized treatment plans were completed by a non-licensed mental health clinical staff and were subsequently reviewed and signed by the program's licensed clinical supervisor within ten days of completion. All five individualized treatment plans were signed by treatment team members who participated in development of the plan, along with a note regarding the parent/guardian participation, when available. Three of the five individualized treatment plans reviewed were applicable for the inclusion of psychiatric services, to include psychotropic medication and frequency monitoring by the psychiatrist. All three individualized treatment plans reflected the required review and monitoring for psychiatric services. Individualized treatment plan reviews were reviewed, for all five youth records. Each of the treatment plan reviews conducted were documented on the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review (MHSA 017) form, each month. Each of the individualized treatment plans documented the on-going prescribed services; individual, group, family, and/or psychiatric services, as needed. Three additional youth records were reviewed for discharge planning. All three of the youth's discharge plans were documented on the Department's Mental Health/Substance Abuse Treatment Discharge Summary (MHSA 011) form. None of the three youth reviewed required any type of notification for suicide risk or precautions. Each of the Mental Health/Substance Abuse Treatment Discharge Summary documented the services required for daily maintenance of positive improvement in behavioral,

emotional, and social skills made by youth during treatment. All three discharge plans contained documentation of the discharge plans having been discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. A copy of the Mental Health/Substance Abuse Treatment Discharge Summaries were provided to the youth, JPOs, and parents/guardians in each of the three youth records reviewed.

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 is contracted to provide specialized treatment for thirty Substance Abuse Treatment Overlay Services (SAOS) beds. The scope of SAOS treatment service delivery is outlined within the contract between the provider and the Department. The program provides urinalysis drug testing upon intake and after each return to the program, with positive tests requiring an appropriate clinical intervention and sanctions. The program provides individual, group, and family therapy as part of each youth's treatment plan. Each service type is created as interventions within a youth's treatment plan. Each youth receives either individual, group, or family therapy seven days a week. Substance abuse groups offered do not exceed ten youth. Each youth receives daily therapeutic activities. A licensed qualified professional, one who provides substance abuse services in accordance with Florida Administrative Code 65D-30.003, is on-site at least five days a week. The program has a substance abuse clinical staff on-site seven days a week. Counselor caseloads for SAOS do not exceed fifteen youth. Interview with the designated mental health clinician authority (DMHCA) reported substance abuse services are provided to the youth through the Seven Challenges groups and individual therapy sessions. Training is provided on the curriculum by a master trainer who has attended a Seven Challenges Leader training. Fidelity monitoring of the groups are provided monthly to each therapist and youth journals are reviewed periodically for therapist fidelity.

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****	

Five youth records were reviewed for psychiatric service delivery. All of the youth records were applicable for psychiatric services referrals. Three of the five youth were on psychotropic medications upon admission to the program. Each of the youth referred were seen within fourteen days of the referral. Each of the initial diagnostic psychiatric interviews included a youth history, mental status examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5), treatment recommendations (if applicable), prescribed medications (if applicable), explanation of the need for psychotropic medication, and frequency of medication monitoring. All five initial diagnostic interviews with the psychiatrist were documented on the Clinical Psychotropic Progress Note (CPPN). All five initial diagnostic interviews were labeled as an "initial diagnostic psychiatric interview." Three of the five initial psychiatric diagnostic interviews resulted in the prescription of psychotropic medication or

changes to youth's existing psychotropic medication regimen. Page three of the CPPN was used to document the psychiatric interview. All three youth on prescribed psychotropic medications were seen for medication monitoring review by the psychiatrist every thirty-days. The program has an independent contract agreement with a psychiatrist, who has completed a psychiatry program approved by the by the American Board of Psychiatry and Neurology, licensed under Chapter 459, Florida Statute and meets all requirements outlined within Florida Administrative Code 63N-1. The psychiatrist's license is clear and active and expires January 31, 2022. The psychiatrist has specialties in pediatrics, child and adolescent psychiatry. A copy of the contract between the program and the psychiatrist was available for review while on-site. The program does not have a psychiatric advanced practice registered nurse (APRN). The psychiatrist is on-site every two-weeks and is available to evaluate and monitor youth, as needed. Review of the psychiatrist's program sign-in sheets reveals two, three-week periods where the doctor's visits fell outside the two-week timeframe. Each youth prescribed psychotropic medication receives psychotropic medication monitoring and review, every thirty days. Review of the psychiatrist medication review revealed two youth had one review which was four days late from the thirty-day requirement. The psychiatrist is available for on-call and provides emergency consultation twenty-four hours a day, seven days a week. The psychiatrist's evaluation and recommendations for the youth is incorporated into the mental health clinical staff's evaluations of the youth and the youth's Individualized Mental Health and Substance Abuse Treatment Plan. The psychiatrist is ultimately responsible for the prescription and monitoring of psychotropic medications at the program. A review of youth records revealed the psychiatrist actively participates in, manages, and supervises psychotropic medication service within the program. An interview with the psychiatrist was conducted and he was asked to describe his role in the coordination and implementation of the psychiatric services provided. He states he is on-site every other week, twice monthly. He meets with the program's designated mental health clinician authority (DMHCA) and program director to discuss youth receiving psychiatric services, monthly. He says he participates in treatment team meetings; which is the formalized process in place to review with healthcare staff to discuss medical issues pertaining to those youth in receipt of psychiatric services. The psychiatrist states he is available to conduct face-to-face or telephonic communication with a representative from the treatment team. The psychiatrist does not have any concerns with the health care at Crestview Youth Academy.

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

The program has a written suicide prevention plan, which details suicide prevention procedures. The program's written suicide prevention plan, includes identification and assessment of youth at risk of suicide, staff training (for total of six hours annually, which includes mock drills), suicide precautions, levels of supervision (one-to-one, constant, and close supervision), referral, communication, notification, documentation, immediate staff response, and a review process. The program's written suicide prevention plan is reviewed annually. The program reports the written suicide prevention plan is reviewed annually; however, the last date the plan was reviewed and signed by the designated mental health clinician authority (DMHCA) and program director was on June 29, 2018.

3.11 Suicide Prevention Services (Critical)	Satisfactory Compliance

Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors.

Any youth exhibiting suicide risk behaviors shall be placed on Suicide Precautions (Precautionary Observation or Secure Observation), and a minimum of constant supervision.

All youth identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations shall be placed on Suicide Precautions and receive an Assessment of Suicide Risk.

Five youth records were reviewed for suicide prevention services. The youth reviewed had an Assessment of Suicide Risk (ASR) completed upon admission to the program. According to the designated mental health clinician authority (DMHCA), all youth admitted to the program are assessed for suicide risk. Four of the five youth were on precautionary observation (PO) by the detention center upon arriving to the program and the PO supervision was continued until an ASR was completed. An ASR referral was generated for all five of the youth reviewed and was completed using the required Department ASR form (MHSA 004). Each youth was screened and the four youth were subsequently placed on standard supervision with the one youth remaining on standard supervision. The PO status was authorized, and mental health staff provided supportive services, as needed. None of the five-youth reviewed, required any type of Follow-Up ASR. Pursuant to Florida Administrative Code 63N-1.00953; youth placed on PO prior to an ASR, who receives an ASR and is not found to be a potential suicide risk may be transitioned directly to standard supervision. Four of the five reviewed youth records documented a conference held between the licensed mental health professional and program director in order to reduce the level of supervision. All five ASRs conducted were completed by the licensed mental health counselor (LMHC). All five-youth assessed for suicide precautions, had an ASR completed within twenty-four hours of the youth admission to the program. Any youth on PO are allowed to participate in select activities with other youth, in designated safe housing areas of the program. Youth on PO were not limited to an individual cell or restricted to his sleeping room. None of the youth assessed were determined to be in crisis upon admission to the program. None of the ASRs were conducted outside of the program. A review of the program's logbook and shift debriefings revealed instructions pertaining to those youth placed on suicide precautions, when necessary. There is no indication the program has had any youth placed on secure observation during the annual compliance review period. Discussions with the DMHCA, also supports the program has not had any youth placed into secure observation. Review of a controlled observation record revealed the youth displayed behaviors which the program's suicide prevention plan and policy dictate, the youth should have been considered a suicide risk and placed on secure observation but was not. Mental health staff did not consult with the youth at the time of the event. The program called Central Communications Center (CCC) as a result of the non-action revealed during the annual compliance review. The program has a written suicide prevention plan, written mental health crisis intervention plan, and written emergency mental health and substance abuse services plan, which address practices for suicide prevention services. The program's written plans identify communication practices in order to notify the juvenile probation officer (JPO) and parent/guardian of the youth's potential suicide risk. In addition, the program's written plans, addresses the facility administrator's review process for every serious suicide attempt or serious self-inflicted injury. A multidisciplinary review includes, circumstances surrounding the event, facility procedures relevant to the incident, training received by involved staff, pertinent medical and mental health services

involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures. The program has two suicide response kits on-site. Each of the suicide response kits contained a knife-for-life, wire cutters, and needle nose pliers. Both of the suicide response kits were located within master control. All five staff interviewed stated, if a youth expressed thoughts of suicide, to notify mental health, search the youth and youth's room for sharp objects, place the youth on a constant sight and sound supervision, and document supervision. All five staff knew the suicide kits were located in master control.

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.	

Two youth records contained precautionary observation (PO) logs as a result of the youth's PO supervision at admission, therefore; an additional record was reviewed. All three of the PO logs reviewed were documented on the Department's Suicide Precautions Log form (MHSA 006.) Each PO log was maintained for the duration the youth was on suicide precautions. Each of the five PO logs documented the appropriate level of supervision and observations of the youth's behavior. There was no noted or need to document warning signs in any of the five PO logs reviewed. Staff recorded observations of youth behaviors in real time, at a minimum of thirty-minute intervals. All three PO logs were reviewed and signed off by each shift supervisor. All of the PO logs were reviewed and signed off by the mental health clinical staff. All three of the PO logs included specific language documenting safe housing areas within the program. One youth was applicable to be interviewed for staff supervision while on suicide precautions and reported staff was with them at all times.

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.	

Ten staff training records were reviewed for suicide prevention training; five pre-service and five in-service. All ten staff completed appropriate pre-service or in-service training related to suicide prevention training. The program has three operating shifts. The program completed a mock suicide drill quarterly and on each shift during the annual compliance review period. All staff who have direct contact, on a day-to-day basis with youth, participated in at least one quarterly mock suicide drill. Each of the mock suicide drills included action to be taken by staff and a method for contacting other program staff by radio or for back-up support to include emergency medical services. In addition, provision of life saving measures, such as cardiopulmonary resuscitation (CPR) and/or the use of the suicide response kit. The program has a process in place which allows staff members when not present during a quarterly mock drill to review each drill scenario and procedures. Interview with the facility administrator confirmed quarterly suicide drills provides staff training on emergency responses, suicide attempts, and 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 written mental health crisis intervention services plan. The written mental health crisis intervention services plan includes the following: notification and alert system, means of referral (which includes, youth self-referral), communication, supervision (one-to-one, constant, and standard supervision), documentation, and a review process.

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

The program did not have any youth requiring a crisis assessment during the annual compliance review period. The program has a written crisis intervention services plan which addresses those practices necessary to effectively handle youth in need of a mental status exam and crisis assessment. The program utilizes the Department's Crisis Assessment form (MHSA 023) and a mental status exam to document reason for conducting an assessment.

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

The program has a written emergency mental health and substance abuse services plan. The written emergency mental health and substance abuse services plan includes immediate staff response, notification, communication, supervision, authorization to transport for emergency mental health services or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act), documentation, training, and a review process.

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

The program did not utilize a Baker Act or Marchman Act procedure during this 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 a medical doctor who serves as the designated health authority (DHA). The DHA is a licensed physician with a clear and active license which expires on January 31, 2022. The DHA meets all requirements for independent and unsupervised practice in Florida. The DHA specializes in family practice. The program does not have a Collaborative Practice Protocol in place, as they do not employ an advanced practice registered nurse or a physician assistant. The DHA is on-site for at least one day each week, for a period of two hours and is available twenty-four hours each day by telephone, if needed. The sign-in and out logs for the previous six-months confirmed the DHA visits as aforementioned. According to the DHA, he provides medical services to the youth seven day a week, twenty-four hours a day, 365 days a year by phone. The DHA is also on-site once a week for sick call, questions, policy review, and to work with the nursing staff on any medical needs

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

The program utilizes Facility Operating Procedures (FOP) and treatment protocols for all health-related concerns. The FOPs and treatment protocols were found to be well organized in separate three-ring binder. All FOPs contained the signatures of the designated health authority (DHA) and the superintendent. Documentation provided showed on January 10, 2020, the FOPs were reviewed and implemented. All treatment protocols contained the signatures of the DHA and each of the nurses working in the program. Documentation confirmed all medical staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures, which was provided by the registered nurse. Documentation confirmed nursing staff completed the annual review of FOPs and signed the cover page.

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

A review of five youth Individual Healthcare Records (IHCR) confirmed each youth had a signed Authority for Evaluation and Treatment (AET). Two of the youth reviewed were eighteen years old and had an AET upon admission. One youth reviewed was involved with the Department of Children and Families; however, the youth's parental rights was not terminated. All AETs were received prior to the youth receiving medical treatment. Each AET was stamped "copy". Copies of the parental notifications were maintained behind the AET in the youth IHCRs. According to the nursing staff interview, AET's are obtained from the Department's Juvenile Justice Information System and placed in the youth's IHCR, a copy stamp is placed on each page of the AET. Original AET's is signed and witnessed by a Department of Juvenile Justice representative.

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.	

A review of five youth Individual Healthcare Records (IHCR) found three were applicable for a parent/guardian notification. The three youth records were reviewed and found each youth was placed on medications not covered by the Authority for Evaluation and Treatment (AET). Each instance documented telephone calls, or attempted telephone contacts, and verbal approvals which were witnessed. In addition, the parental notifications were sent to the parent/guardian when applicable. In two of the three applicable youth records, the Clinical Psychotropic Progress Note (CPPN) was required, both records documented consent on page 3 from the parents/guardian. It is the program's practice of verifying each youth's shot records prior to youth being admitted to the program. A review of five youth IHCRs confirmed the program verified the vaccinations for each youth on the days of admission. According to the nursing staff interview, an immunization consent is sent to the parent/guardian prior to the administration of immunizations. If the parent/guardian refuses, a religious exemption from immunization form is to be filled out from the county health department signed and sent to the program. A copy is placed in the IHCR. According to the nursing staff interview, once a new medication, a change in a medication, or treatment is ordered, a parental notification is completed right away. Parents/guardians are notified verbally and written notifications are made when a new or a change in medication is made.

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.	

Five youth Individual Healthcare Records (IHCR) were reviewed for screenings upon admission for healthcare concerns. Each of the five reviewed IHCRs contained a completed Facility Entry Health Screening (FEPHS) form which was completed on the date of admission, by a registered nurse. One youth was applicable for a rescreening due to leaving the custody of the program staff, upon returning to the program the registered nurse completed a new FEPHS form.

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 maintains a written policy and procedures which requires healthcare staff to orient each youth to the program within twenty-four hours of admission. Five Individual Healthcare Records (IHCR) were reviewed for completion of orientation. In all five IHCRs reviewed, documentation revealed each youth participated in orientation to healthcare services. Each youth received orientation as required. Youth orientation to healthcare services addressed all of the required topics, including access to medical care, sick call, the right to refuse care, and what to do in the case of a sexual assault or attempted sexual assault, what constitutes and emergency, the role of healthcare staff at the program and to notify staff immediately if they are having side effects from medications.

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 maintains a written policy and procedures which requires the designated health authority (DHA) to be notified immediately when a youth admitted requires emergency care or routine notification in accordance with Department requirements. Five youth Individual Healthcare Records (IHCR) were reviewed. Two youth were applicable, one addition youth record was reviewed to meet the minimum sample size of three. The three youth were identified as possessing a medical concern, chronic condition, or taking psychotropic medications. Each of the three IHCRs indicated the DHA was notified by telephone upon the youth admission to the program and each notification was documented in the youth's Chronological Progress Notes, in addition the Chronic Conditions Log also updated as required.

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.	

Five youth Individual Healthcare Records (IHCR) were reviewed. Each record had a completed Health Related History (HRH) form within seven days of admission to the program by a registered nurse. All five HRH forms were new and completed on the day of admission. Documentation provided revealed the designated health authority (DHA) reviewed the HRH forms. Each HRH form was completed prior to completing the Comprehensive Physical Assessment (CPA). According to nursing staff interviews, the HRH is completed by the medical staff within seven days of 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 a written policy and procedures requiring all youth to receive a Comprehensive Physical Assessment (CPA). A review of five youth Individual Healthcare Records (IHCR) revealed a Comprehensive Physical Assessment (CPA) was completed for each youth. Each CPA was completed within seven days of admission by a medical doctor. All five CPAs were new, documented the medical grade for each youth, and were completed as required by Administrative Rule. A review of the Department's Problem List indicated it was updated for each youth, as required. The program has a written policy and procedures outlining all youth are required to be screened for tuberculosis (TB). A review of five youth IHCRs reflected each youth had a minimum of one verified tuberculosis skin test (TST) documented in each youth's IHCR. Each of IHCRs documented Tier One TB screenings were completed within seventy-two hours of admission. There were no further evaluations or treatments needed. The information was documented on each youth's Infectious and Communicable Disease (ICD) form and on the CPA. An interview with the nurse revealed, The CPAs are completed within seven days of admission at the program by the DHA.

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

The program has a policy and procedures regarding the completion of sexually transmitted infection (STI) screenings. Five Individual Healthcare Records (IHCR) were reviewed, of which all five youth reported being sexually active. The program screened each youth for STIs and each youth submitted to a STI test on the day of admission. Five youth IHCRs were reviewed, of which two youth refused human immunodeficiency virus (HIV) testing. A copy of the refusal was filed in the youth's IHCR. The three youth who consented to HIV testing, each received the test and the results were filed in a confidential manner. The results were in a sealed envelope marked confidential within the youth IHCR. Documentation provided showed the program partners with OASIS Florida to provide pre and post-test counseling. Five youth interviews revealed, youth can ask for an HIV test.

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

The program has a policy and procedures in place to conduct sick call for all youth in the program experiencing illness. The program utilizes a lock box in order to ensure youth do not have access to the completed Sick Call forms. All youth in the program can make Sick Call Requests and have their complaints treated appropriately through the Sick Call Process. Sick calls are conducted daily, as needed, by a registered nurse. Medical staff reserve seven days a week from 6:00 a.m. to 6:00 p.m. to address sick calls. When medical staff are not on campus, they are called to conduct sick calls. There were no youth complaints of any severe pain with which medical staff was unfamiliar with. None of the youth presented complaints three or more times within a two-week period. No sick call was observed during the annual compliance review. Sick Call Request forms and narrative progress notes are conformed to the professional standard to include all elements of the subjective, objective, assessment, and plan (SOAP) format and documented treatment, education, and follow-up plans when appropriate. None of the youth reviewed were placed in restricted housing; however, it is the practice when youth are in restricted housing, medical staff provided the necessary medical attention based on the youth's needs. The program documented the Sick Call Log in three ring binders and all Sick Call forms were stored in the youth IHCR. Five staff were interviewed concerning sick calls and all reported the nurses respond to sick calls. Five youth were interviewed, three reported within one day of requesting a sick call seeing a nurse. Two youth reported being seen immediately.

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 an established policy and procedures for the provision of episodic care, first aid, and emergency care. A review of five youth Individual Healthcare Records (IHCR) revealed four youth applicable for episodic care. A review of four applicable youth IHCRs found each

contained appropriate documentation of the episodic care events. Each youth was evaluated and treated by medical staff. The program maintained an Episodic Care Log to document the provision of episodic care and first aid treatment. A review episodic care documentation found subjective, objective, assessment, and plan (SOAP) elements. A review of the logs indicated episodic care was administered by the nursing staff. Documentation also showed one youth's care and treatment was not logged; however, it was documented in the youth's IHCR. The program has a total of four first aid kits. All four were inspected and contained all the approved content, as required, all contents were up-to-date, and all first aid kits were resealed with a tamper tag. The program also has one automated external defibrillators (AEDs), which was tested and were functional during the annual compliance review. The pads were last changed on February 4, 2019 and expire in April 1, 2021. The batteries were last installed on June 15, 2017 and expire September 1, 2022. Documentation and interviews confirmed the nursing staff review inventory and restock all first aid kits monthly and document the review on a log located on each first aid kit. First aid kits were located in master control and in the kitchen. A review of the program medical drills confirmed the program conducts mock emergency medical drills monthly on each shift. Five staff were interviewed, and all reported they were able to call 9-1-1, if a youth has a medical emergency. Five youth interviewed, all reported they can see the doctor if needed.

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

The program has a written policy and procedures to provide timely referrals and coordination of medical services for youth requiring off-site care. A review of five youth individual health care records (IHCR) revealed one was applicable for offsite care; the reviewed documents revealed the youth was transported to the emergency room. Documentation confirmed the designated health authority (DHA) was notified of the emergency event and the youth followed-up with the DHA. The event was documented on the episodic care log. The IHCRs contained a summary of off-site care form and discharge instruction documents.

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

The program has a written policy and procedures for the delivery of treatment to youth identified as having a chronic medical condition. A review of five youth Individual Healthcare Records (IHCR) found two youth were identified with a chronic medical condition at admission, one applicable youth record was pulled. The program identified youth chronic condition by utilizing the FEPHS form. The youth were classified according to their medical grade. The program maintained a chronic conditions roster to document the youth identified with chronic conditions and track the required treatment/evaluation. Periodic evaluations are documented in the youths IHCR, treatments orders are written in a way clinical staff can understand them. Documentation provided confirmed, youth are evaluated prior to new medications being order or prescribed. There were no lapses in treatment and the Department's Problem List was updated. An interview with the registered nurse confirmed, periodic evaluations are conducted every three months or sooner if needed.

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

The program has a written policy and procedures to ensure medication is received, stored, inventoried, and provided in a safe and effective manner. A review of five youth Individual Healthcare Records (IHCR) found three youth were prescribed medication prior to their admission to the program. In each of the three IHCRs, the medication was verified, and the youth was continued on medications. Verification of medication was documented in each youth chronological progress notes and stored in the youths IHCR, the DHA and when applicable the psychiatrist was contacted to obtain orders to resume the youth medication. The program used the standard Department Medication Administration Record (MAR)/Electronic Medical Record (EMR), to document consumption and refusal of medications. The MAR documented all of the required information including medication start and stop dates, and staff and youth initials of medication received. There were no lapses or errors in medication administration. The medical staff document weekly side effects monitoring on the MARs. The program securely stores all medication and sharps separately and inaccessible to youth. Bulk medication is stored in a locked cabinet. Bulk sharps are stored in a lock cabinet. The program stores active medication in a locked medical cart. Oral medications and topical medications are stored separately. Medications requiring refrigeration were stored in a refrigeration only used for medication. All controlled medication is stored within a locked box within the locked medication cart and the medical cart is stored in a locked room within medical when not in use. It is the program practice to destroy all expired medication using Rx Destroyer, in the presence of a registered nurse as a witness. All medication destroyed is tracked and signed off as destroyed. A medication pass was observed using the program's video surveillance system during the annual compliance review. The registered nurse (RN) verified the Six Rights of Medication Delivery/administration (right youth, right medication, right dose, right route, right time, and right documentation). After the RN gave the youth the medication, the RN verified the youth consumed the medication by checking his mouth. The program has trained non-healthcare staff to assist in the delivery of medications, only when licensed staff are not on-site. There were no refusals; however, the program's practice is to clearly document refusals on the MAR and Refusal Form, when applicable. Five staff were interviewed, all reported medication is provided by the nursing staff. Four staff also reported trained/certified staff also provide medication. Five youth were interviewed, three stated they received medication from the nurse and two reported not receiving 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 maintains a written policy and procedures ensuring medical equipment classified as medications/sharps secured and inventoried by using a routine perpetual inventory. The medical staff ensure all medical equipment classified as sharps and medications are secured in designated areas inaccessible to youth. Medications are stored in a locked medication cart, cabinets, and in the locked refrigerator all of which are situated in the medical clinic which is always locked and inaccessible to youth. All medications are stored separately. All controlled medications were stored behind two locks and also two locks in the medical cart. There was

documentation of shift-to-shift counts being conducted. A shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record. A review of the program's inventory was conducted; documentation showed the program secured, locked, and inventoried all medications and medical equipment such as sharps by using a routine perpetual inventory descending count as each sharp is utilized and disposed. A random inventory of three different sharps, three prescribed medications, and three over-the-counter (OTC) medications revealed each count was accurate and documented by licensed nursing staff correctly. A review of the past six months of medications revealed all counts and inventories matched medications on-site. The number of pills, tablets, or dosages remaining after each administered dosage was documented on the youth's individualized Controlled Medication Inventory Record. According to the nurse, the program has an agreement with a consulting pharmacist to inspects the medication area monthly, monitor destruction of medications, controlled meds, Medication Administration Record (MAR), medication storage areas, labeling and expiration dates, refrigerator, and provides a monthly written report.

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

The program has a written policy ensuring all staff and youth receive education on infection control. A review of the program's plan was conducted and confirmed the plan included the implemented infection control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, according to Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. It is the program's policy to screen youth at admission for the purpose of infection control. Five reviewed youth Individual Healthcare Records (IHCR) confirmed each youth received infection control screening at admission. Infection control screening in completed when medical staff complete the youth's Facility Entry Physical Health Screening form, Health Related History form, human immunodeficiency virus (HIV) risk assessment, sexually transmitted infections screening, and the Comprehensive Physical Assessment. Youth upon admission and staff annually receive infection control training, the training included prevention of bloodborne pathogens guidelines for hand-washing techniques, universal/precautions, prevention/transmission of communicable diseases. A copy of the Health Education Record form was maintained in each of the five reviewed IHCRs. According to the program director, the Exposure Control Plan is in nursing and master control and is reviewed at least annually.

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

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

Standard 5: Safety and Security

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

Program staff maintained active supervision of all the youth, including interacting positively with youth, engaging in a full schedule of constructive activities, closely observing behavior of all the youth, and changes in youth behavior. The behavior management system was consistently observed, and the program staff was always able to account for all the youth under their supervision during the annual compliance review period. The staff to youth ratio during daytime activity hours is one to eight and one to twelve during night time hours. On the first day of the review, youth were observed in English class with seven youth, one staff, and a teacher present. All the youth were seated at their desks, the staff was standing at the back of the classroom and the teacher was walking around the classroom giving instructions to the class. On the basketball court there were twelve youth, three staff, and a supervisor. The youth were playing basketball and the three staff were positioned around the court maintaining constant sight and sound of all the youth. On the second day of the review, a math class was observed where there were twelve youth, one staff, and one teacher present. All youth were seated at their desks with the exception of one youth; the staff member was standing at the back of the classroom. Youth were observed on the basketball court where they were playing basketball, there were seventeen youth participating in the basketball game, three staff and a supervisor positioned at different corners of the basketball court within sight and sound of all youth, this is within ratio with one additional supervisor present. On the third day of the review, the youth were observed during transition from school to groups. There were four different transitions with staff to youth ratios remaining at three staff to twelve youth. Staff members were asked on three different occasions what their youth count was and each time the count was correct without the staff having to recount. The policy and procedures always define active supervision as staff being within sight and/or sound of all the youth. The activity schedule is completely planned for each day. The daily schedule is posted behind plexi-glass in each dorm. During all observations of the programming, the youth were busy and did not have any unstructured time. The behavior management system was observed throughout the annual compliance review; the youths' points were called and explained over the radio if the points were either above or below a standard expectation. Staff were able to account for the youth under their supervision at all times. Three staff were asked what the procedure is when they cannot reconcile the count. Each staff stated the supervisor is informed and all youth are returned to their assigned dorms until all youth are accounted for. Each of the five staff interviewed communicated formal youth counts occur each hour and each was able to describe what to do in the event there is a discrepancy in the youth counts.

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) was reviewed. There was an agreement between the program and the school related to the BMS. The BMS is clearly written and is outlined in the youth's handbook. A review of five case management records found each had a signed document by the youth indicating the youth received a copy of the student handbook at admission. Rules governing youth conduct and positive and negative consequences for behaviors are posted and are documented in the youth's handbook. The program's BMS has not been changed since the last annual compliance review period. The BMS was posted in the youth dorms behind plexi-glass. Interviews with five staff and five youth confirmed each understood the BMS. The facility administrator was interviewed and stated, the treatment team monitors consequences in the program through the BMS. The program's written BMS includes the following: maintain order security, promote and protect youth rights, positive and negative consequences, constructive disciplinary actions which are non-punitive, opportunities for a positive reinforcement, recognition of accomplishments and positive behavior at a four to one ratio, promotes socially acceptable means for youth to meet their needs, a process for explaining to the youth the reason for any sanction imposed, an opportunity to explain his behavior, and an opportunity for staff and youth to discuss impact of behaviors on others. Staff and youth interactions were observed for adherence to the BMS, the ratio remained at a minimum of an two staff to eight youth and the positive to negative consequences remained at a four to one ratio; however, there were no negative consequences observed during the annual compliance review. The BMS policy does state there is to be a positive to negative consequence of four to one. Negative consequences are in direct relation to the severity or seriousness of the inappropriate behavior exhibited. There is a variety of rewards and incentives offered through the BMS. The BMS includes special provisions in the provider's contract including but not limited to nightly incentives, off campus trips once youth have reached the appropriate level, token economy store, thirty minutes of video games, and a movie night. Five of five interviewed staff indicated youth have a variety of incentives including token economy store, video game time, and Monday and Friday incentive treats. Five of five youth interviewed indicated there are a verity of types of reward/incentives such as token economy store, video games, playing cards, and other daily incentives. The facility administrator stated the shift supervisor and the assistant facility administrator reviews the point cards daily.

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's written policy and procedures was reviewed to ensure there is a protocol where staff are provided feedback regarding their implementation of the behavior management system (BMS). The youth care worker job description outlines specific qualifications of staff whose job functions includes implementation of the program's BMS. The provider's contract was reviewed and all required parties were involved in the development, implementation, and on-going maintenance of the BMS. The facility administrator stated the youth care workers tally points on the point card and the assistant facility administrator ensures the cards are correctly tabulated. Five of five staff interviewed indicated supervisors monitor staff use of the BMS and provide feedback through reviews and staff incentives. The program's BMS included a process where in staff explain to the youth the reason for any sanction imposed, the youth are given an opportunity to explain their behavior, staff and the youth discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternate acceptable behavior. The program does not utilize room restriction. The BMS does not include; increased length of stay, denial of basic rights, promotion of punishment, punishment of youth by other youth, or disciplinary confinement. Five staff interviewed indicates staff informs the youth if they have a sanction imposed through a meeting with the assistant facility administrator, case manager, and therapist. Four of five interviewed youth indicated they had never been on room restriction with one youth stating they are sent to their room to go to bed early if they are not behaving. Staff has been trained in BMS implementation at the program. The BMS includes special provisions outlined in the provider's contract. Five staff training records were reviewed and revealed completion of the BMS training. Five of five staff indicated they had received a training jointly combined BMS plan to include use of the BMS during school. The facility administrator trained education staff in the jointly combined BMS plan to include use of the BMS during school. Five of five staff indicated they completed BMS training. The facility administrator stated the assistant facility administrator reviews point sheets and referral forms to monitor how consequences are monitored within the program.

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 seventy-one cameras, in which all were operating as required. The facility administrator stated the camera system holds up to thirty days of recordings. Five random days, which included both second and third shifts, were reviewed for completion of ten-minute

observation checks. These checks were compared with the logs written and maintained by staff. The logs and the camera times matched and were less than nine minutes each with staff initials next to each documented check. Three different staff were observed, and all three staff used flashlights when looking in all the youths' rooms when rooms were dark. Five staff were interviewed, and all stated youth checks must be conducted every nine minutes or less.

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's written policy and procedures were reviewed and the youth's census, counts and tracking have been observed to be conducted as required. A review of the program's log book indicates counts are being conducted at the beginning of each shift, after each outdoor activity, and during emergency drills. The Continuity of Operations Plan was reviewed. The program only maintains one log book which is located within the master control room. The log book contains the total daily census count, head counts, youth movements, new admissions, releases, alerts, and youth temporarily away from the program. The log book was reviewed, and counts are conducted as required. There were no emergency counts noted during this annual compliance review period.

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 logbook was reviewed and is bound with numbered pages, without any pages missing or falling apart. All entries are made in ink without erase marks or whited out areas. There were no logbook entries obliterated or removed. All errors are struck through with a single line and dated and initialed by the person correcting the error. All entries include the date time of the event, with the name of the staff and youth involved, a brief description of the event, and the name and signature of the staff making the entry. The program does not utilize a living unit logbook. The program only maintains one logbook, which was in the master control office. The program summarizes in shift reports the event, incidence, and activities documented in this central logbook, and all staff initials the shift report. The program supervisor verbally briefs incoming staff about the contents of the shift reports; all incoming staff will review the shift reports.

Incoming staff sign and date the shift report from the previous shift to document he/she has reviewed or has been verbally briefed about contents. A copy of the shift report is in master control. The program documents incidents, and activities in a central logbook in master control. There were no incidents recorded in the annual compliance review period. Special instructions from supervision and monitoring of youth were noted. Perimeter security checks and other security checks conducted by direct care staff are documented in the logbook. Transports away from the program, including the names of the staff, youth involved, and the destination are documented in the logbook. Request by law enforcement to access any youth is documented in the logbook. Removal from the mainstream population is documented in the logbook. Admissions and releases including the name, date, and time of anticipated arrival or departure and mode of transportation is noted in the logbook. There were no attempted escapes noted during the annual compliance review period. There were no incidents reported to the Florida Abuse Hotline or the Central Communications Center reported during this annual compliance review period.

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

The program's written policy and procedures on key control was reviewed states key assignment and usage including restrictions on usage, inventory and tracking of keys, secure storage of keys not in use, procedures are in place addressing missing or lost keys, and procedures are in place to report and replace damaged keys. The distribution and collection of keys was observed. Master control collects all keys, and no personal keys are permitted to enter the building. The building keys are in the administration building, each staff must enter an assigned number on an electronic combination lock box to obtain and return facility keys. The key inventory was reviewed, and the key inventory matches the actual keys in use. The key storage area was observed and there is a high level of security. Keys are locked master control and only given out in exchange for personal keys. Keys must be returned to master control to obtain personal keys. Damaged keys are logged into a report and replaced by maintenance. The master control operator indicated special area keys are assigned to individuals on their facility roles such as medical, case management, youth care, mental health, and maintenance. The program's method for the daily tracking and reconciliation of keys is to collect transactions each day and pull reports for the team working during the current day. Three direct care staff were checked for personal keys and all three did not have their personal keys. The youth interviews did not indicate if youth had access to keys. Five out of five staff interviewed stated all staff are given a number to check assigned keys in and out of the key control box.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.

The program's written policy and procedures on contraband was reviewed and it aligns with the Department's recommended guidelines. The program conducts searches of every individual entering the program; everyone goes through a metal detector and gets wanded as they enter the building. The program's employee handbook defines what contraband is, and the student handbook indicates the permitted items allowed. The students are provided with a list of items they are permitted to have at the program and are told if something is not on this list, it is considered contraband. The student handbook list consequences for having contraband as a three-day suspension. All common areas, facility grounds, and rooms are searched and logged on the shift briefing forms. The youth are searched as they leave the dining hall, dorms, class rooms, group rooms, and recreation. Incoming mail is opened by the case manager with the youth present. All outgoing mail must remain open until case manager seals the outgoing letter. The program's policy for staff introducing contraband is clear, if a staff brings contraband to the facility the staff will be terminated, and law enforcement maybe involved if contraband is a safety security risk. The program's standard of conduct stated all employees who are found in possession of contraband in the program will be subject to disciplinary action up to and including dismissal which includes administration. As stated in the program's Standard Code of Conduct, introduction of unlawful activity is grounds for termination and potentially the application of criminal charges under Florida Statute which is a felony of the third degree. The program clearly delineates items considered contraband, to include, but not limited to the following illegal items, sharps, escape paraphernalia, drugs, to include prescription or over the counter medications, tobacco products, electric or vaporless cigarettes, non-program-Department of Juvenile Justice issued program equipment, and/or devices, unauthorized food or beverage, metals, cell phones, cash, keys or any item not deemed safe to security. The program documents confiscation and disposition of contraband on discipline reports. The documentation was maintained in five out of five youth case records reviewed. There was no illegal contraband found during the annual compliance review period. No illegal contraband disposal was documented in the case records. Facility logbook, incident reports are conducted daily and include the results of each search. The facility administrator was interviewed and stated anyone involved in bringing in illegal contraband would be immediately terminated, and law enforcement would be notified.

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.	

Youth searches were observed before and after groups. Youth searches were observed before transport. There were no searches available to watch during intake during the annual compliance review. There was no visitation available to observe searches. Youth were observed between education transitions and were searched before leaving the classroom and randomly searched before entering the next class room. The youth were treated with dignity and respect during searches. The searches were conduct by the two staff and all searches were completed by male staff. The searches were pat searches completed with a four-quadrant approach, and youth were thanked and encouraged before going into the next class. Searches are being completed as Protective Action Response (PAR) standards dictate. Five out of five youth interviewed indicate the searches are conducted after each movement. Five out of five staff stated searches are conducted 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 two vehicles used for transporting youth. Invoices from automotive shop were reviewed and indicated both vehicles received their annual safety inspection and there were no deficiencies. Vehicles were used for transporting youth were observed and they are equipped with a safety screen separating the front seat from the back seat and a staff occupies the back seat with the youth. Five staff were interviewed, and all understand the consistency of seatbelt usage. Personal vehicles were checked, and all vehicles were locked. All vehicles currently being used to transport youth have annual safety inspection documentation, maintenance records documented, vehicles are secured at all times, fire extinguisher, approved first aid kit is available in master control to be checked out, seat belt cutter, window punch, appropriate number seat belts, youth are not attached to any part of the vehicle by any means other than proper use of a seat belt, and the door to the youth passenger area cannot be opened from the inside.

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

The program has a written policy and procedures in compliance of all requirements outlined by the Department relating to transportation of youth and driver eligibility. One to five staff to youth ratio is in place for transportation. A transport cell phone and/or radio is available to staff. If the transport is across the street to the juvenile detention center, a radio is utilized. One staff of the same gender as the youth is maintained on all transports. One transportation was observed, and ratio was maintained with two staff and one youth. The program maintains two vehicles

equipped properly for all transports. A program vehicle sign-in and out log is maintained. A random check of personal vehicles was conducted to ensure all vehicles are kept locked in the parking lot. A staff driver list was provided in which all drivers records were checked for accuracy. There were no discrepancies found. Five interviewed staff reported they are provided communication devices when transporting youth. All five staff reported they are not allowed to transport youth in personal vehicles.

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

The program has a policy and procedures which outlines the weekly safety and security audits. The policy indicates who is responsible for conducting the weekly audits and the implementation of corrective actions as deemed necessary by deficiencies found during any internal and/or external review, audit, and inspections and procedures were reviewed to ensure all requirements of Florida Administrative Code 63E-7.017 (5) was followed. Sample weekly safety and security audit documents were reviewed and found to meet all requirements. Audits are conducted on a weekly basis. The facility administrator stated all areas of the program are reviewed during the weekly audit and are emailed to the Department of Juvenile Justice's residential safety and security monitor.

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 maintains a written policy and procedures which addresses the issuance, inventory, and control of all tools. The procedure outlines the process for missing and/or lost tools. There were no reports of missing or lost tools during the scope of the annual compliance review. All tools are marked with an identifying number. The maintenance person conducts a daily inventory of all tools with sharp edges and a monthly inventory of all other tools. The inventory includes items of tools signing in and out. Kitchen tools were also observed and are inventoried daily. Kitchen knives were secured in a locked box. Any dysfunctional tools are disposed of and replaced as needed. The program prohibits machetes, bowie knives, or other long blade knives. All staff were found to have completed training for the intended and safe use of tools as part of their pre-service training requirements. All tools observed were accounted for based on inventories reviewed. Youth do not handle tools or are allowed in the area where tools are stored. Five of five staff interviewed reported youth can use mops and brooms. One staff also reported they can use a screwdriver or hammer under the supervision of maintenance.

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's procedures for the supervision requirements when youth use tools were reviewed. The program's procedure for using tools for youth and staff, including youth's risks to self and others was reviewed. The program's procedure to determine the established ratios, tool distribution and collection, and search criteria was reviewed. Staff to youth ratio was maintained at one staff to five youth during activities using tools and one staff to three youth during discipline work projects. Youth were observed completing work detail in the dorms, the staff to

youth ratio was maintained. Youth are searched after each work project. Three risk assessments were reviewed, and three of three youth had risk assessments completed. Risk assessments are completed on youth participating in tool projects or activities. Five of five youth were interviewed and indicated they can use 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 a written policy and procedures for addressing outside contractors when entering the program to perform a work project which requires the use of tools. Approved vendors who enter the program must have his/her tools inventoried by the supervisor or designee. An Outside Contractor On-Site Work Project Log is completed when entering the program, which lists the tools. All tools will be checked going in and out. When a contractor is on-site, no youth are allowed in the work area. A review of project invoices submitted to the program by the vendor was completed and the sign-in sheets matched the dates of the projects which were completed. Personal cell phones are prohibited from entering the secure program area. Only the program director can approve cell phones or other devices.

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 Continuity of Operations Plan (COOP) plan was reviewed and the program conducts practice drills and is prepared for immediate implementation or mobilization of plans whenever an emergency or disaster situation is necessary. The program conducts fire drills at a minimum of two every month, the program conducts safety drills of different emergencies yearly, evacuation and disaster drills are completed yearly. Fire evacuation routes and egress plans are posted throughout the program. Disaster drills and suicide drills were completed quarterly. Further review of drill documentation found fire drills were completed as required. Five of five youth indicated they had participated in drills. Five of five interviewed staff reported they have participated in fire drills and in other drills such as weather, bomb threat, chemical spill, suicide and medical, and escape drills. The facility administrator reported fire drills, and medical drills are completed monthly. Suicide and disaster drills are completed quarterly.

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 Continuity of Operations Plan (COOP) plan was easily accessible and located within the master control room. The COOP is readily available to staff. The plan was updated and submitted to the Department of Juvenile Justice (DJJ) residential regional administrator on March 19, 2019. The program's COOP addressed alternative housing plans approved by the DJJ regional administrator. Provision of equipment and supplies required for continuous operation and services were observed. The facility administrator stated the COOP was in the master control room. The plan contained the following: fire and fire prevention and evacuation, severe weather, program disturbances, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff rolls and responsibilities, any equipment and supplies needed, information about youth may be needed, alternative housing arrangements, provisions of continuity of care and custody of youth, and provisions for public protection. The program maintains all required critical identifying information for each youth in an administrative hard-copy file which is easily accessible and mobile in the event of an emergency resulting in the program relocating quickly, or in the event the information may not be obtained electronically.

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

The program has a written policy and procedures which addressed flammable, poisonous, and toxic item control. The policy requires these items to be stored in secure areas which are inaccessible to youth. These items were observed to be secured in the following areas: Outside chemical storage shed, outside secured closet, and in a secured cabinet inside the bathroom in the kitchen area. The program stores the flammable materials such as diesel, gas, or pesticides outside the program in a metal storage unit in the sally-port. The program maintained an accurate inventory of all the chemicals, flammables, and toxics which are in each applicable area. The only person authorized to handle these items in the program is the maintenance manager. A review of each item observed found the corresponding Safety Data Sheets (SDS). The binder also included a copy of the program's operating procedure for flammable, poisonous, and toxic control items, as well as a copy of the chemical disposal protocol. Only maintenance staff has a key to have access to the chemical storage areas. SDS are kept within a binder in each storage unit 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 maintains strict control of flammable, poisonous, and toxic items and materials. The program's written policy and procedures prohibit youth from handling flammable, poisonous, and toxic items and/or materials. All items are strictly maintained outside the secure buildings and is inaccessible to youth. No youth were observed handling chemicals. Youth interviews revealed they are not prohibited to handle any chemicals. Five youth interviews were conducted. One youth reported using window or toilet cleaner but stated he did not handle the chemical directly. He stated staff spray the chemical and the youth wipes it off. The remaining four youth stated they do not use any chemicals at the program.

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

The program has a written policy and procedures which addressed flammable, poisonous, and toxic control, and the disposal of these items. The maintenance manager is the only individual authorized to dispose of these items. There was no documentation provided indicating maintenance received training for disposing hazardous items and toxic materials. The maintenance manager stated he follows the Safety Data Sheets (SDS) sheets for disposal of these items. Kitchen grease is disposed of in a metal grease vat which is located outside the secure area. Disposal of the kitchen grease is completed with a bio-hazardous waste contractor (Superior Industrial Services). This is being completed monthly. According to the maintenance manager, all corrosive and flammable items are disposed of through a hazardous waste container taken by Okaloosa Recycling and Hazardous Waste. Hazardous waste is disposed of in accordance with the SDS and stored in a hazardous storage area. Liquid wastes, such as dirty mop water, are disposed of in plumbing drains. All kitchen liquid waste, except grease, is disposed of in the kitchen and it goes into the grease trap. Grease is placed in a separate container for disposal. If there is a chemical spill, staff will notify master control of the location. The shift supervisor/master control directs the shutdown of all air handlers and ventilation systems and closes all windows and doors at the direction of the on-site supervisor. Assistance from outside the facility is contacted as necessary, consistent with emergency procedures. The facility administrator was interviewed and stated the maintenance

manager places items on disposal lists and transports material to waste management for hazardous material disposal.

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.*	

This program does not participate in water activities; therefore, this indicator is rated as non-applicable.

5.22 Visitation and Communication	Satisfactory Compliance
The program allows visitation and communication for youth while in the program.	

The program has a written policy and procedures outlining the procedure for visitation and access to correspondence and telephone. Visitation for the youth is held on Saturday from 1:00 p.m. to 4:00 p.m. The visitation schedule is posted in the front lobby. Upon arrival, each youth receives a youth handbook which details the visitation and communication process. Family members are required to sign-in on a separate visitor sign-in sheet. The program makes alternative visitation arrangements for parents/guardians if needed. All documentation reviewed was complete and in order, and all requirements were met. Case management staff is responsible for maintaining the youth’s authorized telephone, mail, and visitation list. Youth

have the capability of writing two letters a week and may earn extra letters and phone calls through the behavior management system. Incoming and outgoing mail is searched in the presence of the youth. Five interviewed youth all reported they can communicate and correspond with family members through mail, telephone, and visitation.

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

The program has a policy and procedure in place for the use of Controlled Observation. Observations of the Controlled Observation Room found the room met all requirements. The program reported having three Controlled Observations during the scope of the annual compliance review period. Three Controlled Observations were reviewed and found evidence staff documented an inspection of the room prior to placing youth in the room or leaving him alone. Staff of the same gender searched the youth before the youth is left alone in the Controlled Observation Room.

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

A review of Controlled Observation Report incidents was completed. During the past six months, three Controlled Observation incidents were reported. Two of the three times the youth was not exhibiting behaviors indicative of a mental health crisis or suicide. Three of three times supervisory or higher-level staff authorized placement. Three of three instances the youth presented with violent behavior which if continued was likely to result in immediate injury or harm to self or others and substantial property damage. Three of three times youth presented as psychically out of control, less restrictive methods appeared ineffective; staff needed to gain quick control and order for program safety and security. Staff advised youth for the reason of placement in the Controlled Observation and expected behavior for removal. A health care professional or staff of the same gender as the youth completed the Health Status Checklist. No complaint or injuries were observed in three of three cases. The amount of time in Controlled Observation was twenty minutes, two hours and thirty-three minutes, and forty-three minutes. The program administrator granted permission one out of three times to extend time in Controlled Observation after two hours, youth was released after two hours and twenty-three minutes. The facility administrator designates supervisory or higher-level staff to approve placement of any youth in Controlled Observation.

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

Staff designation for Controlled Observations are included in the program's written policy and procedures. A review of three Controlled Observation Reports was completed. Staff making placement in Controlled Observation completed the first page of the Controlled Observation Report and submitted this to the supervisor. Staff conducted and documented safety checks at least every fifteen minutes and observed each youth's behavior. Staff documented all safety

checks and observations on the Controlled Observation Safety Check forms. The facility administrator or supervisor who has delegated authority gives written approval before youth is released from Controlled Observation. The administrative staff reviewed the Controlled Observation Reports within fourteen days of the youth's release from Controlled Observation to determine if the placement was appropriate. Staff decided to include in-house alerts were warranted for each of the three youth when the youth were released from Controlled Observation.

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

Five youth safety plans were reviewed, with all five developed in the required timeframes. Parent/guardian interviews were conducted to help develop the safety plans. Staff interviews found several staff were unfamiliar with the term safety plan. The facility administrator was interviewed and stated the staff are not familiar with the term safety plan, as they are referred to as the My Stress Plan, which is completed initially and every thirty days. The plans address youth warning signs, baseline behaviors, crisis recognition, coping strategies defined by the youth, intervention strategies preferred by the youth, and debriefing preferences. The plans incorporated recommendations when needed from previous clinical assessments and were inclusive of trauma responsive practices. All My Stress Plans included all required elements of 63E-7.01 (5) Florida Administrative Code. Plans were updated every thirty days or following any significant behavioral or mental health event identified by the treatment team. Safety plans are maintained accessible to staff. Five youth interviews revealed five of five youth stating they were involved in the development of their safety plans.