STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Center For Success and Independence - Ocala

Youth Opportunity Invesments, LLC
(Contract Provider)
4055 NW 105th St
Ocala, Florida 34482

Review Date(s): October 20-23, 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:

Tara Gilligan, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Renette Crosby, Office of Accountability and Program Support, Regional Monitor (Standard 1)
LeAnn Gruentzel, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Kristine Harshaw, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Jennifer Schad, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Kimberly Schneider, DJJ Probation, Circuit 5, Senior Juvenile Probation Officer (Standard 2)
Donna Stanton, TrueCore Behavioral, Health Services Administrator (Standard 4)

Program Name: Center for Success and Independence Ocala
Provider Name: Youth Opportunity Investments, LLC
Location: Marion County / Circuit 5
Review Date(s): October 20-23, 2020

MQI Program Code: 1449
Contract Number: 10575
Number of Beds: 72
Lead Reviewer Code: 188

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.14 Internal Alerts System and Alerts (JJIS)*	

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicles and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Management	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 Supervision 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 *	Satisfactory
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The Center for Success and Independence – Ocala is a seventy-two bed program, for fifteen to eighteen year old males, located in Ocala, Florida. The program is operated by Youth Opportunity Investments, LLC, through a contract with the Department. The program provides substance abuse overlay services (SAOS) and mental health overlay services (MHOS). The program fosters youth by providing Trauma Focused Cognitive Behavioral Therapy, Seven Challenges, Skillstreaming the Adolescent, Young Men's Work, Moral Reconation Therapy, and Impact of Crime. Additional treatment services provided includes family and individual therapy. Program administration is comprised of a facility administrator, assistant facility administrator, human resources business manager, and chief of security. Case management services are provided by one case manager supervisor, two transition services managers, and four case managers. Mental health staff at the program includes a clinical director, clinical coordinator, contracted psychiatrist, five master's-level therapists, and a contracted behavioral analyst. Medical services are offered seven days a week and are provided by one registered nurse who also serves as the health services administrator (HSA), and two additional full-time registered nurses. The program has a contract with a physician who serves as the designated health authority (DHA). Educational services are provided by the Marion County School Board. The layout of the program includes two dormitories, an administration building, a dining hall, kitchen, four portables which serve as classrooms, and a building which houses medical, as well as two conference rooms. The program has 140 operating security cameras providing coverage. At the time of the annual compliance review, the program had eight vacant positions including one facility administrator, one clinical director, one assistant clinical director, and five case managers.

Strengths and Innovative Approaches

- The program has a Horse Care program. Each youth has the opportunity to participate in the Horse Care program. Youth are taught the role of the caretaker, along with safety, professionalism, and handling of the horses. In addition, the program is in the process of becoming a partner with the Ocala/Marion County Chamber and Economic Partnership.

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.	

Twenty-eight employees were reviewed for initial background screenings. All twenty-eight staff records documented each staff had a background screening completed prior to the date of hire. Each of the records reflected a criminal history report was reviewed. None of the employees were rated ineligible and none had a break in service. The program's contract reflects the program shall perform pre-employment assessments using a suitability assessment tool for all prospective employees providing direct care to youth prior to hiring. The program's facility operating procedures regarding background screening states: An applicant, or volunteer cannot have contact with the youth or confidential youth records until the employee successfully passes the Diana Screening (the pre-employment assessment tool chosen by the program), an "eligible" background screening has been received, and the applicant's Florida public criminal history report has been received and reviewed by the hiring authority. A pre-employment screening was found in all twenty-eight employee records. A review of documentation in each record confirmed the hiring authority reviewed Central Communications Center (CCC) person involvement reports, Staff Verification System (SVS) module, and Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) results. The program added twenty-seven of the twenty-eight employees to the Clearinghouse employment roster. The one remaining record was not added, as the employee is no longer employed by the program. The program did not have any interns or volunteers. An Annual Affidavit of Compliance Level 2 Screening Standards (Form IG/BSU-006) was completed and sent to the Department's Background Screening Unity on January 8, 2020. The teachers who are paid by the school board, or have funding provided by the school board or Department of Education, received an annual screening on January 10, 2020.

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

The program has a policy and procedures which indicates all staff will receiving a background rescreening every five years of employment/service and the five-year resubmission will be completed on or before the five-year anniversary date. There were no employees eligible for the five-year rescreening.

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

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

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

The program has a policy and procedures regarding the provision of an abuse-free environment. Seven staff personnel records were reviewed, and each reflected staff adhere to a code of conduct, as indicated by the staff's signature. The Florida Abuse Hotline and Central Communications Center (CCC) number were observed posted throughout the program. The program's abuse reporting policy documents the steps to report allegations of abuse. These steps include staff providing telephone access to report allegations of abuse, the shift supervisor is notified immediately of a youth's request, and the shift supervisor shall immediately attempt to notify the facility administrator of the abuse call. The staff will assist youth in placing the abuse call by dialing the phone number, recording the date and time of call, obtaining the operator's name and number, and documenting the information on the internal incident report. In the event a youth changes his mind and no longer wants to make the call, staff ensures the youth's refusal of the call is documented in the facility logbook and on the internal incident report, the shift supervisor completes an internal incident report documenting the youth's statement and all information shall be submitted to the facility administrator before the end of the shift, and the administer on duty shall ensure all appropriate notifications are made. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment on June 30, 2020. The program had seven incidents regarding physical, psychological, or emotional abuse during the previous six months. A review of documentation indicated all seven incidents were reported to the CCC within two hours. Two of the incidents were reported to the Florida Abuse Hotline. Four incidents are still in progress, and the remaining three were unsubstantiated.

All seven interviewed youth reported they feel safe at the program and none of the youth have ever been stopped from reporting abuse. Six youth stated staff are respectful when talking to them. One youth stated staff are respectful most of the time. Five youth reported never hearing staff use profanity and two reported staff use profanity often. Six of the seven interviewed staff indicated if a youth requests to make an abuse call, they would notify the supervisor and allow

the youth to make the call. One staff indicated the supervisor makes the call, and one staff indicated the facility administrator would be notified. All staff stated they have never observed a co-worker tell a youth they could not call the Florida Abuse Hotline. All seven staff stated they have never observed a co-worker using profanity, threats, intimidation, or humiliation when interacting with youth. The facility administrator confirmed the program's staff code of conduct indicated how staff will represent the department and the program along with how staff will protect individuals from the misconduct of others, interfere with operations, discredit the company, or is offensive to staff, youth, and families. The program uses a progressive corrective action system and does not tolerate offenses in which physical abuse, threats or profanity towards youth.

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.	

An interview with the facility administrator indicated staff and youth are knowledgeable in contacting the Florida Abuse Hotline or Central Communications Center (CCC) through postings throughout the program. Additionally, all incidents are tracked in the program's incident report tracker and all calls to the Florida Abuse Hotline and CCC are discussed during the daily management meeting sand daily shift briefings for all shifts and professional staff. There were no incidents of disciplinary actions due to allegations of abuse toward youth; however, in all seven CCC reports where improper use of force, excessive force, or improper conduct was cited, the staff members were removed from contact with youth pending an internal investigation.

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 reported sixty-four incidents to the Central Communications Center (CCC) during the previous six months. Forty-two of the CCC incidents were related to the COVID-19 pandemic. Each of the six incidents reviewed documented the incident was reported within two hours of the program becoming aware of the incident, as required. All six reports were documented in the logbook. There were no internal incidents or grievances reviewed which should have been reported to the CCC.

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

The program has a Protective Action Response (PAR) plan which was approved by the Department on October 8, 2019. In the last six months, there have been twenty-six PAR

incidents, of which five were reviewed. In all five PAR reports, documentation confirmed the reports were completed by the end of the staff member's workdays and the reports included statements from all staff involved. None of the incidents resulted in the injury to youth or staff. In all five incidents, there was a review by a PAR certified instructor or supervisory staff. None of the incidents were applicable for a PAR Medical Review. All reports reflected a Post-PAR interview was conducted with the youth by an administrator within thirty minutes of the incident, and the incident report was reviewed by the administrator within seventy-two hours of the incident. A copy of the PAR report was placed in the program's centralized file within forty-eight hours of approval by the facility administrator in all five incidents. For the last six months, monthly summaries maintained by the program of all PAR incidents were submitted to the Department's regional office by the fifteenth of each month. The program experienced an increase in the number of PAR incidents by one incident, since the last annual compliance review. The program has a review process in place ensuring incidents requiring PAR are reviewed and discussed, including incidents reviewed by video to ensure the interventions followed the PAR policy. The program's PAR rate during the annual compliance review period was 2.20, which is below the statewide residential PAR rate of 2.23.

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

The program submitted, in writing, a list of pre-service trainings to the Office of Staff Development and Training which includes course names, descriptions, objectives, and training hours for any instructor-led training based on the pre-service certification topics on June 23, 2020. Seven staff records were reviewed for pre-service training. Each staff completed over 120 hours of training; however, one staff did not complete the trainings required based on the training plan. Two staff did not complete trainings which are considered essential skills which must be completed prior to any contact with youth. One of the two staff did not complete cardiopulmonary resuscitation, first aid, automated external defibrillator, or emergency procedures. The remaining staff did not completed emergency procedures. Four of the seven staff records documented staff completed active shooter training. The remaining three records did not have documentation indicating staff completed the training. All completed trainings were documented in the Department's Learning Management System (SkillPro) within thirty days of completing training for seven staff. The program's contract specifies youth care worker IIIs, shift supervisors, and unit managers are to complete certified behavioral health technician training within six months of hire; however, none of the reviewed records were applicable for this training.

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

The program submitted, in writing, a list of all in-service training to the Office of Staff Development and Training including course names, descriptions, objectives, and training hours for any instructor-led training January 1, 2020, and the training plan was signed on February 6,

2020. The program has an annual in-service training calendar which is updated as changes occur. The program had no staff eligible for in-service training.

1.09 Grievance Process	Satisfactory Compliance
Program staff shall be trained on the program's youth grievance process and procedures. The program adheres to their grievance process and shall ensure it is explained to youth during orientation and grievance forms are available throughout the facility. *Completed grievances shall be maintained by the program for a minimum of twelve months.*	

The program has a policy and procedures regarding the grievance process. Seven staff training records were reviewed and reflected all seven staff received training on the grievance process. The program's grievance process includes informal, formal, and appeal phases. The informal phase includes Let's Talk forms which are reviewed with youth by staff to reach a resolution through verbal communication. The formal phase includes grievance forms available to youth in the housing area which are to be completed and submitted into a secure box. The forms are assigned to staff in daily management meetings and are the be reviewed and investigated within two days of assignment. If not resolved within two days, supervisory staff will investigate and respond within two days, and efforts will be made to conclude the grievance within five workings days. Grievances may be appealed to the facility administrator or the assistant facility administrator. The program maintains a grievance binder which contains copies of grievances filed for the past twelve months. Four grievances were filed in the past twelve months. All grievances were resolved in the formal phase. One grievance was resolved the same day and three grievances were resolved the following day. Six of the seven interviewed youth indicated forms are placed throughout the facility. All youth indicated they can ask for assistance in completing the form. One youth indicated there are three phases of the process. Two youth indicated there are timeframes for each phase. All seven interviewed staff indicated grievance forms are placed throughout the facility. Three staff indicated the facility administrator reviews grievances. Six staff indicated youth can request assistance in completing the forms. Four staff indicated the process had three phases; each phase has associated timeframes, and grievances are reviewed by a supervisor. The facility administrator indicated there are three phases of the grievance process beginning with the attempt to resolve the grievance between the writer and grievance officer.

1.10 Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement interventions for each youth. Interventions shall include, but are not limited to, evidence-based practices, promising practices, or practices with demonstrated effectiveness. Staff whose regularly assigned job duties include the implementation of a specific intervention and/or curriculum must receive training in its effective implementation.	

The program utilizes Impact of Crime, a promising practice curriculum, designed to reduce the influence of specific risk factors related to re-offending behavior based upon the youth's assessment. The program utilizes Seven Challenges, a promising practice curriculum, designed to address youth with substance abuse related issues. The program utilizes Trauma Focused Cognitive Behavioral Therapy which is an evidence-based practice intended to assist youth in recovering from trauma. In addition, the program utilizes Skillstreaming the Adolescent with demonstrated effectiveness to assist youth with prosocial skills, mental health trauma, and substance abuse relate issues. The program provides Young Men's Work as a gender-specific programming group to the youth. The facility administrator confirmed staff education and work

experience are used to determine if a staff member possesses the skills to deliver services. Further, youth are matched with staff, counselors, and case managers based on the youth's specific needs and which staff can best help youth throughout the course of treatment. Staff training records were reviewed and confirmed the staff providing the interventions had the required training in the intervention and education. A review of the program's activity schedule reflected the program is providing structured, planned programming or activities at least sixty percent of the youth's awake hours. A review of group sign-in sheets indicated the groups were delivered, as indicated on the program's schedule. A review of three youth records showed all three youth are involved in a delinquency intervention which is evidence-based, promising practice, or any other intervention approved by the Department. All three youth were involved in a delinquency intervention addressing an identified priority needs as identified by the Residential Assessment for Youth (RAY). Each of the performance plans addressed an identified priority need.

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 and social skills through Skillstreaming the Adolescent. Youth receive life and social skills interventions specifically addressing communication, interpersonal relationships and interactions, non-violet conflict resolution, anger management, and critical thinking, including problem-solving and decision-making. An interview with the facility administrator indicated daily group sessions are facilitated by a trained mental health professional using evidenced-based curricula, unit managers teach hygiene and insurance and finance are taught by education. A review of the program's schedule reflected life skills groups were provided, which was confirmed through group sign-in sheets. All seven interviewed youth listed skills learned in group and referenced practicing skills in and out of group.

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

The program addresses restorative justice awareness for youth through the implementation of Impact of Crime (IOC) and community service projects. Restorative justice activities and instruction are designed to assist youth in accepting responsibility for harm the youth have caused by past criminal acts, challenging the youth to recognize and modify irresponsible thinking; teach youth about the impact of crime on victims, their families, and their communities; expose youth to victims' perspectives through victim speakers, and engage youth in follow-up activities to process their reactions to each victim's accounting of how crime affected their life; and provide opportunities for youth to plan and participate in reparation activities intended to restore victims and communities, such a restitution activities and community service projects. Youth are taught personal accountability, the ripple effect of crime, managing conflict and reparations. Staff conducting IOC groups each had the required training, as documented in the training records. The program's activity schedule and group sign-in sheets confirmed restorative justice groups were provided and conducted as scheduled. An IOC group was unable to be reviewed during the annual compliance review.

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

The program's contract lists Young Men's Work and Talks My Father Never Had with Me as the required services which are to be provided to address gender-specific programming. A review of sign-in sheets confirmed the program provided both groups to address the characteristics of the primary target population (age, gender, and service needs), as required. The group's activity scheduled provides for gender-specific programming.

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

The program has a written policy and procedures to determine how alerts are identified, documented, updated, and communicated to staff. Program alerts were consistent with the alerts which are in the Department's Juvenile Justice Information System (JJIS). A review of seven youth records reflected all nine alerts were verified and removed or downgraded by the appropriate staff. The health services administrator (HSA) addressed all medical alerts. Four of the nine alerts reviewed were entered late. Two alerts were entered sixty-one days late, one was entered seventy-eights days late, and one was entered thirteen days late. Mental health alerts, such as suicide alerts, are addressed by the clinical director. The facility administrator indicated alerts are reviewed with the healthcare staff by the HSA daily for dissemination of relevant healthcare information, and the HSA meets with the designated health authority (DHA) weekly. During these meetings, all pertinent information as it relates to the health and wellbeing of all youth throughout the program is discussed. Four of the seven interviewed staff indicated staff are informed of alerts through logbooks and daily debriefings, two indicated staff are informed of alerts through the programs alert board, and one staff indicated treatment team meetings inform staff of alerts.

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

The program separates the youth record into an individual healthcare and individual management record. The individual healthcare record is further divided into two separate files:

health and mental health/substance abuse. The file tab on the individual management record documented the youth's name, Department identification number, date of birth, county of residence, and committing offense. The individual management record contains the following sections: legal information, demographic and chronolectal information, correspondence, case management and treatment team activities, and miscellaneous. Youth records were labeled "Confidential." All official youth records are secured in a locked file cabinet in a locked room. 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 in place to promote constructive input by youth. The program's efforts to solicit input from youth were reviewed and include avenues such as weekly youth advisory board minutes, program surveys, and suggestion forms. Seven youth were interviewed regarding the process for youth to provide input and six youth indicated the program conducts house meetings daily, as well as weekly and bi-weekly meetings, while one youth stated they participate in youth group three times a week to discuss youth schedules and activities. The facility administrator indicated youth have access to Let's Talk forms which upon completion, staff meet with youth to discuss any issues or concerns. Youth are also able to express issues or concerns during weekly house meetings and treatment team meetings.

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 quarterly. Meetings were held virtually due to COVID-19 safety precautions. A review of sign-in sheets confirmed the community advisory board met, as required. Documentation confirmed the facility administrator (FA) solicited active involvement from law enforcement, the judiciary community, community partners, business community, school district, faith community, victims, victim advocates, or other victim services community representatives, and a parent/guardian whose child was previously in the juvenile justice system. Sign-in sheets confirmed participation from all members. The FA explained the individuals involved in the advisory board relay the recommendations during the quarterly meeting or by contacting the FA or assistant facility administrator directly. The advisory board conducts religion studies on Fridays, veteran's appreciation, and moments of silence.

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

The facility administrator (FA) ensures provisions for staffing including a system of communication to keep staff informed and provide opportunities to submit input and feedback pertaining to operations of the program. Staff retention planning includes steps to minimize turnover and improve staff morale. The FA explained the program has recently implemented a morale committee to address the needs of the staff, as such, the program has been able to keep a full complement of staff for most of the year. Staff participate in prosocial activities off

campus, as well as staff appreciation weeks and special events. The program has been successful in promoting from within which has increased staff retention.

The program utilizes surveys from youth and parents/guardians, which are discussed monthly, and are used to plan activities and determine which areas of the program are in need of supportive assistance. Morning management meetings are held daily with all management staff. A daily debriefing is conducted with each shift. Weekly meetings are held with shift supervisors, and survey results of any Department reports are shared in monthly all-staff meetings. Six of the seven interviewed staff reported meetings are held daily, one staff reported meetings are held weekly, and five staff also reported meetings are held monthly. Topics discussed include policies and procedures, training, alerts, personnel issues, current trends, staff morale, information from previous shifts, and protocol changes. Two staff stated the topics were valuable and informative. All seven staff stated staff are briefed on youth and parent/guardian survey results. One staff stated communication amongst staff is very good, four believe it is good, one believes it is fair, and one believes it is poor. Concerns regarding communication included missed information and poor communication from management.

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

The program has a policy and procedures which addresses the program's system for evaluating staff, performance standards, and frequency of evaluations. The program conducts an initial ninety-day review and annual reviews thereafter for all staff. A review of seven position descriptions reflected each staff's performance standards were clearly identified and matched the job descriptions for each staff. The program's contract was reviewed to ensure all specific contractually required positions were maintained and performed as outlined in the contract. Each of the seven reviewed staff records contained an initial ninety-day performance evaluation. The facility administrator indicated all staff who have been employed for a year have an annual evaluation in the month of October. This evaluation is the formal evaluation which depicts how the staff has performed throughout the course of the year. Identified in these evaluations are the staff strengths and weakness. Upon completion of the evaluation process, each staff meets with the facility administrator and the manager to discuss areas of improvements and to develop a plan for success. Seven staff were interviewed regarding how often they receive a formal evaluation of their performance based on their performance standards. Four staff stated they receive a yearly evaluation, two stated they received one every ninety days, and one staff member stated they never received an evaluation.

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

The program's policy and procedures addressing the provision of activities based on the developmental levels and needs of the youth in the program. The program maintains an activity schedule which documents a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth for at least one hour daily. A review of the logbook confirmed the activities are documented according to the program's activity schedule. Activities include a choice of leisure and recreation, youth are encouraged to explore interests, and youth were observed engaged in constructive use of leisure time. Activities offered by the program 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. Inside recreation is conducted on days when the weather is inclement (raining or too hot), youth with an existing illness or physical injury are placed on sports restriction until cleared by a medical professional. The program has a formal process to promote constructive input by youth through a youth advisory board which meets weekly. All seven interviewed staff reported youth receive one hour of recreation a day. Examples of activities included board games, football, basketball, writing family, watching movies, and playing cards and video games. Each of the seven interviewed youth reported receiving one hour of recreation each day. The youth listed activities as basketball, football, and kickball. An amendment to the program's contract executed August 28, 2020 removed the requirement for a recreational therapist. Prior to the amendment, the program did have a recreational therapist who met all requirements.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures to address initial contact with the youth's parent/guardian, juvenile probation officer (JPO), and committing court. Seven case management records were reviewed. Each of the seven records contained documentation indicating the program notified the youth's parent/guardian on the day of youth's admission. All records included written notification to the youth's parent/guardian within the forty-eight-hours, as required. A review of documentation confirmed the program contacted each of the youth's juvenile probation officers, post-residential services counselors, and committing courts within five working days of the youth's admission 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.	

The program has a policy and procedures to provide an orientation to each youth on the day of admission. Each of the seven reviewed case management records documented the youth received an orientation within twenty-four hours of admission to the program. The orientation process included all required elements All seven interviewed youth reported orientation to the program was completed on the day 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.	

The program has a policy and procedures to address obtaining written consent for youth who are eighteen years of age or older. None of the seven reviewed youth case management records were applicable for youth eighteen years of age or older; therefore, three applicable closed case management records were reviewed. Each of the applicable records contained a signed written consent from the youth and each consent was obtained prior to discussing any physical or mental health screenings, assessments, or treatments with the youth's parent/guardian, Agency of Persons with Disabilities (APD), or Department of Children and Families (DCF).

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

The program has a policy and procedures to address the classification process and reassessment for activities. Seven case management records were reviewed. Each of the reviewed records contained documentation indicating the youth were initially classified on the date of admission to the program. The classification forms documented a review of all required factors including the youth's physical characteristics, age, maturity level, special needs, including mental, developmental, intellectual, and physical disabilities, history of violence, applicable gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, and identified or suspected medical, suicide, escape, or security risks. When the initial assessment was completed, the information was used to assign new youth to a living unit, sleeping room, and youth group/staff advisor. All records contained a completed Victimization and Sexually Aggressive Behavior (VSAB) assessment. Five of the seven records were applicable for reassessments. All five applicable records documented reassessments were completed during treatment team meetings, as warranted. The facility administrator (FA) was interviewed and reported the youths' mental health, physical health, cognitive performance, age, and prior victimization were considered when assigning a youth to a living unit.

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

The program has a policy and procedures addressing gang affiliation and to ensure law enforcement is notified of this information. Two of the seven reviewed youth case management records were applicable for gang affiliation; therefore, one additional applicable record was reviewed. All three applicable records documented the program notified local law enforcement regarding the youth's gang status. The program provided notification to the youth's juvenile probation officer, local school district, and the law enforcement agency in youth's home county. A gang alert was entered into the Department's Juvenile Justice Information System (JJIS) for each youth.

2.06 Gang Identification: Prevention and Intervention Activities	Satisfactory Compliance
A residential commitment program shall implement gang prevention and intervention strategies. The residential commitment program shall provide intervention strategies when youth are identified as being a criminal street gang member, are affiliated with any criminal street gang, or are affiliated with any criminal street gang, or are at high risk of gang involvement.	

The program has a policy and procedures addressing gang prevention and intervention activities. Two of the seven reviewed youth case management records were applicable for gang

affiliation; therefore, one additional applicable file was provided for review. Each of the three applicable youth case management records documented the youth participated in monthly gang prevention and intervention strategies. Intervention strategies provided by the program include Gang Resistance and Drug Education (GRADE). Monthly gang meetings were held with youth who were found to be in need gang prevention/awareness efforts. All three reviewed performance plans included gang interventions. The program uses a gang notebook containing a sign-in sheet and completed training material by each youth.

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

The program has a policy and procedures to address the completion of Residential Assessment for Youth (RAY) and reassessments. Each of the seven reviewed youth case management records contained an initial RAY which was completed within thirty days of the youth's admission into the program. Six of the seven youth were applicable for RAY reassessments, and five were completed within the required ninety-day timeframe. The remaining RAY reassessment was completed forty-eight days late. The program maintained all reassessment documentation in the youth's official case records.

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

The program has a policy and procedures to address the completion of a Youth Needs Assessment Summary (YNAS)within thirty days of a youth's admission. All seven reviewed youth case management records contained a YNAS. Six of the seven YNASs were completed within thirty days of admission to the program. The remaining YNAS was completed one day late. Each of the YNASs were documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures to address the intervention and multidisciplinary treatment team. Each of the seven reviewed youth case management records contained performance plans which were completed within the required thirty-day timeframe and developed after the youth's initial assessment. All seven performance plans documented participation by all required parties, including the youth's parent/guardian. One youth's plan documented participation of a Department of Children and Families caseworker, as required. Each of the performance plans included goals for the youth to complete prior to release from the program, as well as the youth's top three criminogenic needs. The goals were based on prioritized needs of the risk and protective factors identified during the initial assessment. All goals contained target dates for completion, court-ordered sanctions which could be reasonably completed in the program, youth responsibilities to accomplish the goals, and the program's responsibilities to assist the youth to achieve the goals. Each of the performance plans were signed by the youth, treatment team leader, and all parties who had significant responsibilities in goal completion. All seven records documented the performance plans were sent to the youth's committing court, juvenile probation officer (JPO), and parent/guardian within ten working days of the plan completion. All seven interviewed youth reported they participated in the development of the performance plan, knew their current performance plan goals, and had a copy of the performance plan.

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

The program has a policy and procedures to address revisions to youth's individualized performance plan when determined necessary by the intervention and treatment team. Each of the seven reviewed youth case management records documented revisions to the youth's performance plan. Each of the seven youth records contained at least one monthly review due to a Residential Assessment for Youth (RAY) reassessments, newly acquired information, and progress towards completing goals. Of the three applicable records, all three youth's performance plan revisions included a lack of progress toward goal completion. Three of the seven youth were applicable for transition activities. Each of the three performance plans included revisions to facilitate transition activities during the last sixty days of 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.*	

The program has a policy and procedures to address performance summaries and transmittals. Six of the seven reviewed youth case management records contained performance summaries completed every ninety days following the signing of the youth's performance pan, or at shorter intervals when requested by the committing court. One of the seven records was not applicable due to the youth transferring to this program, from another residential program, changing the due date of the timeframes. Each of the seven summaries included the youth's status on each performance plan goal, treatment process, academic status, behavior, level of motivation or readiness to change, interaction with peers and staff, the overall behavior adjustment to the program, and significant positive and negative changes. Each of the records documented the youth were allowed to read and add comments to the summary prior to signing, were provided a copy of the summary, and contained a copy of the original summary. All seven original summaries were signed by all required parties. Each of the three applicable records contained documentation indicating copies of the performance summary were sent to each youth's juvenile probation officer, committing judge, and parent/guardian within ten days of completion of the summary. Each of three applicable records contained the original summary, along with justification for release, was sent with the Pre-Release Notification (PRN) to the juvenile probation officer (JPO), the release summary and PRN were sent within seventy-two hours of admission or at least forty-five days prior to release. A signed copy of the PRN was retained in two of the youth's case management records. At the time of the annual compliance review, one PRN had not been signed or returned to the program for the remaining record. The court objected to one youth's release. As such, the program resubmitted the PRN and performance summary after the youth made progress towards meeting the courts expectations. Of the two applicable records with approved PRN's, the program provided written notification to the youth's parent/guardian of the planned release. None of the youth were applicable for a Residential Assessment for Youth (RAY), as the program does not complete them until the day before the youth's release. None of the youth were applicable for the sexually violent predator programs. Performance summaries and transition plans were provided to the JPO for the three applicable youth records. Two youth records were applicable to a Victim Notification and Release letter. In both records the letter was sent to the victim at least ten days prior to release. Seven youth were interviewed. All seven youth indicated they were provided a copy of their performance summary which was sent to the court.

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

The program has a policy and procedures to address the inclusion of a youth's parent/guardian in the case management process. All seven reviewed youth case management records

documented the case manager sent an admission letter to the parent/guardian and included the dates/times for the youth's treatment team meetings. All records had documentation indicating the parent/guardian was involved in the assessment process and participated in the development of the youth's performance plan. Reviewed documentation reflected a copy of the performance plan was mailed to each parent/guardian with a request to sign and return the signature page. There was documentation indicating the parent/guardian was contacted for each treatment team meeting in each of the records. All seven interviewed youth reported their parents/guardians were involved in the case management process.

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

The program has a policy and procedures to address the members of the treatment team. The case manager is identified as the treatment team leader. The program's treatment team members consist of the case manager/treatment team leader, youth, representatives from program administration, education, the youth's living unit, mental health, education, medical, the youth's parent/guardian, juvenile probation officer (JPO), and, when applicable, the transition case manager. When applicable, the team includes the Department of Children and Families (DCF) case worker. All seven reviewed youth case management records documented the notification to the required participants of the treatment team. All forms contained signatures from required team members who attended each treatment team. The case manager documented if team members participated by telephone. A copy of the treatment team meeting documentation was mailed to each parent/guardian and JPO with a request to sign and return the signature page in all records.

2.14 Incorporation of Other Plans into Performance Plans	Satisfactory Compliance
The youth's performance plan shall reference or incorporate the youth's treatment or care plan.	

The program has a policy and procedures to address the incorporation of other plans into a youth's performance plan. Each of the seven reviewed youth case management records found the youth's academic and treatment plans were included in the individualized performance plan.

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

The program has a policy and procedures to ensure treatment teams are required to meet every thirty days to formally review each youth's performance, to include Residential Assessment for Youth (RAY) Reassessment results, progress on individualized performance plan goals, and positive and negative behavior, including behavior which resulted in physical interventions. The policy requires the case manager to conduct informal reviews of each youth's performance monthly. The case manager meets with the youth during informal reviews and uses input from treatment team members, as needed. All seven reviewed youth case management records

documented formal treatment team reviews were conducted at least every thirty days. Documentation for each of the formal treatment team meetings included the youth's name, date of review, comments from treatment team members, progress in the program, progress of goals, behaviors, skills, treatment progress and RAY results. Each of the records reflected informal treatment team meetings were held monthly. Documentation for all informal treatment team meetings included the youth's name, date of review, comments from treatment team members, progress in the program, progress of goals, behaviors, skills, and treatment progress. All seven interviewed youth reported they were provided an opportunity to demonstrate skills during the treatment team meetings and staff review their performance to include progress on the performance plan goals, behaviors, and treatment progress.

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

The program has a policy and procedures to provide career education based on age and appropriate for the educational abilities of the youth in the program. The program provides Type 2 career education development which includes personal accountability skills, as well as completing employment applications. An interview with the facility administrator (FA) revealed the program provides Safe Staff for food handler training, cardiopulmonary resuscitation (CPR), first aid, occupational safety and health administration (OSHA), and Microsoft Office certifications. The lead teacher indicated the program offers forklift certification. All three reviewed closed youth case management records included a résumé, completed employment applications, a calendar identifying an appointment with the youth's local Career Source Center, appropriate documents essential to obtaining employment, and documentation to support the youth's parent/guardian and juvenile probation officer were made aware of the youth's vocational plan. One youth record contained a state-issued identification (ID) card. The program was not able to obtain an ID card for the two remaining youth due to the parent/guardian failing to provide the youth's social security card and birth certificate to the program. None of the records contained a copy of the youth's birth certificates. One record documented the youth's parent/guardian didn't provide a birth certificate to the program; therefore, an ID card was not obtained. The remaining record documentation indicating the program attempted to obtain a copy of the youth's birth certificate and ID card; however, the youth's parent/guardian did not provide the documentation to the program.

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

The program has a policy and procedures to provide for educational access. Marion County Public Schools provides educational classes on a 250-day calendar distributed over twelve months which includes a minimum twenty-five instructional hours each week A review of the daily school schedule revealed there are six, fifty-two minute classes beginning at 8:30 a.m. and ending at 3:10 p.m., with an hour and twelve minute lunch break from 11:14 a.m. to 12:26 p.m. An interview with the facility administrator (FA) revealed there is minimal disruption of class during school hours. All seven interviewed youth reported there were no interruptions during the school day. An interview with the lead educator revealed the youth receive credits for the education and training received while in the program. The lead teacher verified the youth attend school daily according to the daily schedule.

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

The program maintains a written policy and procedures requiring an educational transition plan to be developed upon admission. Each of the reviewed closed youth case management records included an individual education transition plan, developed upon entry, and included the youth's post-release goals. Included in each record was an Electronic Educational Exit Plan (EEEP) which identified the next educational placement information and input from the post-release school district representative. All three plans documented the specific monitoring responsibilities by individuals 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.*	

The program has a policy and procedures regarding transition planning, conferences, and Community Re-Entry Team (CRT) meetings. One of the seven reviewed youth case management records was applicable for transition activities; therefore, two additional applicable closed records were reviewed. Each of the three records documented the transition conference was conducted for the youth at least sixty days prior to the youth's release. Documentation for the transition conferences reflected the youth, treatment team leader, facility administrator or designee, and other treatment team members participated in each of the conferences. If participation is not possible, members are invited to provide written input prior to the meeting. Documentation for each of the conferences reflected the team reviewed the youth's transition activities on the youth's performance plan, identified additional transitional activities, target completion dates, and identified persons responsible for completion. The treatment team leader obtained signatures of all applicable members in each of the records. A CRT meeting invite was documented in all records. Reviewed documentation in each record confirmed the CRT meeting was held prior to the youth's release and both the youth and case manager participated during the meeting.

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

The program has a policy and procedures to assemble an exit portfolio for each youth to assist with transitioning back into to community. One of the seven reviewed youth case management records was applicable for an exit portfolio; therefore, two additional applicable closed records were reviewed. All three applicable records documented the exit portfolios were discussed and initiated during the transition conferences. All three exit portfolios contained the youth's transition plan, a calendar with all dates, times and locations of upcoming community appointments, educational/vocational certificates, educational records, transcripts, resume, and sample employment applications. Two of three exit portfolios did not contain a social security card or birth certificate; however, the case manager documented attempts to gain the information from the parents/guardians. One youth already possessed a State of Florida identification card, as such, obtaining the social security card or birth certificate were not necessary. Signatures on each youth's release paperwork confirmed the youth received the exit portfolios upon release from the program. All records documented the exit portfolios were forwarded to the youth's juvenile probation officers, as required.

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

The program has a policy and procedures to address exit conferences. One of the seven reviewed youth case management records was applicable for an exit conference; therefore, two additional applicable closed records were reviewed. Each of the three applicable records documented an exit conference was conducted at least fourteen days prior to the youth's release date and after the juvenile probation officer (JPO) was notified of the release. All records had documented the exit conference dates, signatures, summaries pending transition goals. A review of the exit conference documentation for each youth confirmed the treatment team leader, parent/guardian, education representative, therapist, JPO, youth, and other pertinent parties participated in the exit conference. Each record documented the status of transition activities and finalized plans for the youth's release. The youth's date of admission and date of release correlated in the Department's Juvenile Justice Information System (JJIS). Documentation revealed each exit conference was held separate from the transition and Community Re-Entry Team meetings.

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

The program has a policy and procedures to address safety planning for each youth. Safety plans are kept in the briefing room for the floor staff. Each of the seven reviewed safety plans documented the youth's warning signs, baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies preferred by youth, and debriefing preferences. All of the safety plans were completed within fourteen days of the youth's admission and were jointly prepared by youth, parent/guardian, clinical staff, and behavioral specialist (if applicable). Each

of the safety plans incorporated recommendations from previous or current clinical assessments or screening instruments. All seven records documented safety plans were updated for each youth every thirty days. All seven interviewed youth confirmed they were involved in the development of their safety plans. Each of the seven interviewed staff knew the location of the safety plans.

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 designated mental health clinician authority (DMHCA) position is currently filled by the regional clinical director who is a licensed mental health counselor (LMHC). The DMHCA has a clear and active license in the State of Florida which expires March 31, 2021. The DMHCA is a qualified supervisor mental health counselor, qualified supervisor clinical social worker, and qualified supervisor marriage family therapist. The previous DMHCA resigned effective September 30, 2020 and the position has not yet been filled. The previous DMHCA was a licensed psychologist with a clear and active license in the State of Florida which expires May 31, 2022. The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services in the program. At a minimum, the current DMHCA is on-site weekly for a sufficient time to ensure appropriate coordination and implementation of mental health and substance abuse services are taking place. A copy of the license and position description was reviewed. Back-up for the DMHCA includes two DMHCAs from other programs from the same provider. Both back-up DMHCAs are LMHCs with clear and active licenses in the State of Florida which both expire March 31, 2021. An interview with the DMHCA revealed youth are assigned to a therapist based on treatment needs and therapist experience. The DMHCA assigns therapists to groups and ensure the groups are facilitated according to the schedule and contract. Additional responsibilities for the DMHCA includes reviewing documentation daily for clinical services and providing immediate feedback. The DMHCA conducts group fidelity monitoring for each group monthly.

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

The designated mental health clinician authority (DHMCA) ensures the licensed clinical staff working under their supervision are performing services which they are qualified to provide based on education, training, and experience. The program has one other licensed clinical staff position, the assistant director of clinical services. At the time of the annual compliance review, the position had been vacant since August 3, 2020. The previous assistant director of clinical services was a licensed mental health counselor with a clear and active license in the State of Florida which expires March 31, 2021. A copy of the license was reviewed. The program is licensed in accordance with Chapter 397, Florida Statutes to provide substance abuse services. The license is current, expiring April 1, 2021.

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

The designated mental health clinician authority (DMHCA) assures the non-licensed clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The non-licensed clinical staff schedule indicates clinical staff are on-site seven days a week. The program has five non-licensed mental health clinical staff providing mental health and substance abuse services in accordance with the current contract. Three of the non-licensed staff have been employed at the program since the last annual compliance review and two were hired since the review. A review of documentation reflected the current DMHCA, the previous DMHCA, or the assistant director of clinical services, all licensed staff, provided one hour a week of on-site face-to-face supervision with the non-licensed clinical staff, with one exception. There was no supervision provided the week of September 30, 2020, which is the week the previous DMHCA resigned. The weekly supervision is documented on the Department's Licensed Professionals Direct Supervision Log (MHSA019). Each of the five non-licensed mental health clinical staff hold the appropriate master's-level of education necessary and in accordance with the current contract. All five staff have master's-level degrees in social work, counseling, or marriage family therapy. Three of the non-licensed clinical staff have received twenty hours training in conducting assessment of suicide risk (ASR). Two non-licensed clinical staff are in the process of the training.

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

The program has a policy and procedures regarding mental health and substance abuse admission screenings. Seven youth treatment records were reviewed. All seven records had documentation existing mental health and substance abuse information was reviewed from each youth's commitment packet. All seven youth had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) administered on the day of admission. Each MAYSI-2 screening was completed by trained staff and completed in the Department's Juvenile Justice Information System (JJIS). Three MAYSI-2 assessments indicated a further assessment was required. None of the youth had an indication of "suicide ideation" on the MAYSI-2. It is the program's policy for all newly admitted youth to be referred for a comprehensive mental health substance abuse evaluation and administered an Assessment of Suicide Risk (ASR) as part of the intake process. Documentation confirmed each youth had an ASR during intake. Additional screenings completed by the program at intake include the Substance Abuse Subtle Screening Inventory (SASSI-2), Suicide Probability Scale (SPS), and Beck Depression Inventory (BDI). An interview with the facility administrator confirmed the screening procedures, as outlined in the program's policy.

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

The program has a policy and procedures regarding mental health and substance abuse assessments and evaluations. Seven youth treatment records were reviewed. Documentation reflected each youth was referred for a new mental health evaluation on the day of admission, as required by program policy. All seven youth had a mental health evaluation completed within thirty calendar days of admission. Each of the evaluations were completed by a non-licensed mental health clinical staff and signed by a licensed mental health professional within ten calendar days after the evaluation was conducted. The new evaluations included identifying information, reasons for evaluation, relevant background information, behavioral observations, mental status examinations, interviews or procedures administered, discussions of findings, diagnostic impressions, and recommendations. Each evaluation included a substance abuse assessment with patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, and risk factors of continued alcohol and other drug abuse. Each evaluation addressed the reason for the referral.

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

The program has a policy and procedures regarding mental health and substance abuse treatment. Seven youth treatment records were reviewed. All seven youth were assigned to a treatment team upon arrival to the program. The multidisciplinary team was comprised of the youth, program administration, direct care staff, education, medical staff, and mental health staff. Treatment team meeting documentation validated the teams were comprised of representatives from mental health and substance abuse, case manager, direct care staff, medical, and education. Documentation in all reviewed records revealed youth received individual, group, and family counseling by a licensed qualified professional or a non-licensed substance abuse substance abuse clinical staff working under the direct supervision of a qualified professional. One youth had no exceptions, as services were received as prescribed on the individualized treatment plan. Five of the individualized treatment plans did not match the services delivered initially. Each of the five plans were corrected in August 2020, between two and four months after the youth were admitted. The services delivered matched the individualized treatment plans since the revisions. One youth had the individualized treatment plan revised in July and again in August, four and five months after admission. The plan revision in July prescribed Moral Reconation Therapy (MRT) three times a week. Since August 31, 2020, MRT was only delivered twice a week.

All seven of the youth records had a properly executed Authority for Treatment and Evaluation form. All seven youth had a signed Department Consent for Substance Abuse Treatment and Release of Substance Abuse Treatment Records forms (MHSA012 and MHSA013). Each of the

youth had documented diagnoses listed on the treatment plans and treatment plan reviews. Treatment progress notes were documented on a form containing all required information similar to Department Counseling/Therapy Progress Note form (MHSA018). Group therapy was limited to ten or fewer youth for mental health groups and fifteen or fewer youth for substance abuse groups. Each treatment plan included the frequency of prescribed services for each youth to include individual therapy sessions, group therapy sessions, and family therapy sessions. All staff providing group were qualified to provide services and only clinical staff were providing services. All seven interviewed youth confirmed receiving family and individual counseling. The youth stated individual counseling is held weekly and family counseling is monthly. Seven staff were interviewed, and all seven confirmed direct-care staff do not conduct mental health or substance abuse groups. An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides services, as dictated on a variety of curricula, and fidelity checks are conducted regularly to assure compliance with requirements.

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

The program has a policy and procedures regarding mental health and substance abuse treatment and discharge planning. All seven reviewed youth treatment records contained an initial treatment plan developed on the day of the youth's admission. The initial mental health and substance abuse plan was documented on a form containing all the required information similar to Department's Initial Mental Health/Substance Abuse Treatment Plan form (MHSA015). Each initial treatment plan was signed by the mental health clinical staff completing the form. Five of the initial treatment plans were completed by a licensed clinical staff. The remaining two initial treatment plans were completed by a non-licensed clinical staff and signed by the licensed mental health professional within one day of completion. Each initial treatment plan was signed by all treatment team members who participated in the development of the plan. Each initial treatment plan included the youth's psychiatric needs, including an initial evaluation by the program's psychiatrist.

All seven individualized treatment plans were developed for each youth within thirty days of admission. The individualized treatment plan was developed on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form (MHSA016). Each individualized treatment plan was signed by the non-licensed mental health clinical staff completing the plan and signed by a licensed mental health professional within ten days of completion, as required. Each plan was signed by all treatment team members who participated in the development of the plan. All seven plans were missing the signatures of the youth's parent/guardian; however, documentation indicated the youth's parent/guardians participated by phone. Reviewed documentation reflected the plans were mailed to the parent/guardian; however, the signature pages were not returned to the program. Three youth records were applicable for psychiatric services. Each of the three applicable treatment plans included psychotropic medications and

frequency of medications, as required. Each record documented the youth had treatment plan reviews every thirty days following the development of the individualized treatment plan. The treatment plan reviews were documented on the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form (MHSA017). Each of the seven treatment plans documented individualized services for each youth. Each of the plans documented youth were to receive individual therapy once a week, group therapy seven days a week, and family therapy once a month. Progress notes determined all youth received services, as stipulated on the treatment plans with no exceptions.

Three closed youth treatment records were reviewed for discharge plans. All three closed records had a discharge plan documented on Department Mental Health/Substance Abuse Treatment Discharge Summary form (MHSA011). None of the youth records documented the youth had a suicide risk upon release. Each discharge plan included a recommendation of follow-up services for daily maintenance. All three records documented the discharge plans were discussed with the youth, parents/guardian, and juvenile probation officers (JPO) during the exit conferences. A review of documentation in each record indicated a copy of the discharge plan was provided to the youth, parent/guardian, and JPO.

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 both mental health overlay services (MHOS) and substance abuse treatment overlay services (SAOS). Each youth receives services which includes individual, group, and or family counseling, seven days a week. Daily therapeutic activities are provided by mental health clinical staff. Psychiatric services are provided weekly. The program has a licensed mental health professional on-site at least five days a week. Mental health groups provided do not exceed ten youth and substance abuse groups do not exceed fifteen youth for each group. Each of the clinical staff are on-site forty hours each week, including weekends, to ensure on-site coverage is maintained seven days a week. A review of seven youth treatment records confirmed mental health and substance abuse services were provided seven days a week. An interview with the designated mental health clinician authority indicated additional interventions provided include Seven Challenges, Trauma Focused Cognitive Behavioral Therapy, Skillstreaming the Adolescent, Young Men's Work, and Moral Reconation Therapy. Seven Challenges and MRT are delivered three times a week. The non-licensed mental health clinical staff carry caseloads of fifteen youth or less.

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

The program has a contract with a psychiatrist to provide services on-site weekly. Seven youth treatment records were reviewed. Two youth were admitted into the program on psychotropic medication. One youth was prescribed psychotropic medication subsequent to the youth's

admission. Each youth had an initial diagnostic psychiatric interview conducted which included the youth's medical history, mental health history, substance abuse history, mental status examination, documented diagnosis, and treatment recommendations. Two of the seven records were applicable for psychotropic medications. Both interviews documented the prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring, as required. The evaluation was clearly identified as an "initial" diagnostic psychiatric interview. Page three of the Clinical Psychotropic Progress Note (CPPN) was completed for each youth.

Each youth who entered the program on psychotropic medication received a full psychiatric evaluation within thirty days of admission, as required. All applicable records contained documentation indicating the youth had been seen for a medication review by the psychiatrist at a minimum, every thirty days. The psychotropic medication prescribed included identifying information, diagnosis, target symptoms of each medication, name of medication, side effects, youth's adherence to the medication regime, and height, weight, and blood pressure of the youth. Reviewed documentation reflected contact was made with the youth's parent/guardian, and included a dated signature by the psychiatrist. For two applicable youth, there was documentation of Tardive Dyskinesia monitoring at least monthly.

The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. The psychiatrist meets with members of the treatment team monthly, to discuss each youth scheduled for treatment team. The psychiatrist meets with the health services administrator weekly to review any changes of youth on psychotropic medications. The psychiatrist's recommendations for the youth are incorporated into the youth's individualized treatment plan. A review of documentation for the past six months confirms the psychiatrist is on-site weekly, with no exceptions. The psychiatrist has a clear and active license to practice in the State of Florida expiring January 31, 2022. The psychiatrist has ultimate responsibility for the prescription and monitoring of psychotropic medications in the program. The psychiatrist actively participates in, manages and supervises psychotropic medication services in the program. The psychiatrist's duties and responsibilities are not delegated. An interview with the psychiatrist confirmed his role in the coordination and implementation of psychiatric services in the program is to evaluate youth, coordinate care, and manage medication.

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 policy and procedures regarding suicide prevention services to include a written plan detailing suicide prevention procedure. The plan includes identification and assessment of youth at risk of suicide, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process which includes suicide attempts and a mortality review. The plan includes staff training of six hours annually. The plan is reviewed annually and was last reviewed October 12, 2020 by the new acting facility administrator.

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

The program has a policy and procedures to conduct an Assessment of Suicide Risk (ASR) for each youth admitted to the program. Seven youth treatment records were reviewed. All seven youth had an ASR at intake and, as a result, all seven were placed on standard supervision. One youth was admitted from the detention center, already on precaution observation (PO) with an open alert in the Department's Juvenile Justice Information System (JJIS) already entered; the program removed the alert upon completion of the ASR. One of the seven youth records was applicable for placement on PO; therefore, two additional applicable records were reviewed. For the three incidents, the youth were determined to be a risk based on staff observations of youth. For each incident, PO was authorized. An ASR was completed for each incident, resulting in one youth placed on standard supervision and two youth placed on constant supervision. For the two youth, mental health staff provided supportive services and a follow-up ASR was completed prior to the removal of youth from PO. For each youth, a conference was held with the facility administrator prior to reducing the level of supervision. Discontinuation of close supervision was in accordance with the program's suicide prevention plan. There was documentation indicating the program notified the youth's juvenile probation officer and parent/guardian of the youth's potential suicide risk, as indicated by the ASRs. One of the ASRs was completed by non-licensed clinical staff under the supervision of a licensed mental health professional. The ASR was reviewed and signed by a licensed mental health professional on the same day. Two of the ASRs were completed by a licensed mental health professional. Each youth had an alert entered into the JJIS. PO allowed the youth to participate in select activities with other youths in designated safe housing areas of the facility. PO did not limit the youth's activity or restrict the youth to a sleeping room. There was documentation in the logbook documenting each youth and each incident on PO.

Each ASR was completed in the required timeframe. Each ASR completed by a non-licensed mental health clinical staff was signed by a licensed mental health professional (LMHP) the next time an LMHP was on-site. There was documentation on the ASR of the actual date and time the clinician conferred with the facility administrator or designee. The program does not utilize secure observation and there was no indication secure observation was used. None of the youth were transported off-site while on PO. The youth's level of supervision was reduced only after a conference with the facility administrator.

The program has a seven suicide response kits. Kits are located in master control, in each of the two dorm, sub-control, one in the medical clinic, and three for the transportation vans. The facility administrator has an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide as part of the program's suicide prevention plan. The review includes circumstances surrounding the event, procedures relevant to the incident, all relevant training received by involved staff, pertinent

medical and mental health services involving the victim, possible precipitating factors, and recommendations for any changes, if needed. Seven staff were interviewed. All seven staff knew the location of one or more suicide response. Each of the staff described the procedures in place if a youth expresses suicidal thoughts.

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

The program has a policy and procedures in place regarding suicide precaution observation (PO) logs. Seven youth treatment records were reviewed. All seven youth had an ASR completed during intake and, as a result, all seven were placed on standard supervision. One youth was admitted from the detention center, already on PO with an open alert in the Department's Juvenile Justice Information System (JJIS) already entered; the program removed the alert upon completion of the ASR. One of the seven reviewed records was applicable for placement on PO; therefore, two additional applicable records were reviewed. Each of the youth were determined to be a risk based on staff observations of youth. PO was authorized for each youth. An ASR was completed for each incident, resulting in one youth placed on standard supervision and two youth placed on constant supervision. The youth were placed on PO as soon as staff determined the youth were at risk for suicide. The PO logs for all three incidents were maintained for the duration the youth was on suicide precaution. The appropriate level of supervision and observations of the youth's behavior were documented in real time and did not exceed thirty-minute intervals. No warning signs were documented on the PO logs. Each PO log was reviewed and signed by a shift supervisor and by a mental health clinical staff. The PO logs documented safe housing requirements. Three youth who had been placed on PO were interviewed and confirmed while on PO, staff were with them at all times and they were never left alone.

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.	

Seven staff training records were reviewed. All seven staff had a minimum of six hours annually of suicide prevention and implementation of suicide precautions. The six hours of training included two hours of web-based training in the Department's Learning Management System (SkillPro) and four hours of instructor-led or webinar training. The last four completed quarters were reviewed for suicide drills. A drill was conducted each quarter on each shift. Sixty staff were reviewed, and documentation supported each staff participated in at least one suicide drill in the last year. Suicide drills include the use of cardiopulmonary resuscitation (CPR), the suicide response kit, and the automated external defibrillator (AED). There was documentation to confirm staff members who were not present during a quarterly drill had the opportunity to review each drill during the program's All Staff meeting. Seven staff were interviewed, and all seven stated medical emergency and suicide drills are conducted monthly.

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 policy and procedures regarding mental health crisis intervention services which includes written crisis intervention procedures. The crisis intervention plan includes notification and alert system, means of referral, communication, supervision, documentation, and review. The plan is reviewed annually and was last reviewed October 12, 2020 by the new acting facility administrator.

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

The program has a written crisis intervention plan which includes a process for implementation of a crisis assessment form. One of the seven youth treatment records was applicable for a crisis assessment. The program provided the only additional applicable record for review. Both applicable records documented the youth had a crisis assessment completed the same date the youth was determined to be in crisis. The crisis assessments documented the reasons for the assessment, mental status examinations and interview, determination of danger to self or others, initial clinical impressions, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notifications to the parents/guardians. One crisis assessment was conducted by a non-licensed mental health clinical staff and reviewed by a licensed clinical staff. The crisis assessment completed by the non-licensed staff was reviewed by a licensed mental health professional within twenty-four hours, as required. The other crisis assessment was completed by a licensed mental health professional. Both crisis assessments required a mental health alert to be entered into the Department's Juvenile Justice Information System. Each youth required close supervision, which was appropriately documented on the Mental Health Alert – Observation Log (MHSA 007) form. Neither youth required transportation off-site for the crisis. Both youth had a follow-up mental status examination by a licensed mental health professional. Neither of the youth were involved in a Prison Rape Elimination Act (PREA) event.

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

The program has a policy and procedures regarding emergency mental health and substance abuse services which includes a written mental health and substance abuse plan. The emergency mental health and substance abuse services plan includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Baker Act, transport for emergency substance abuse assessment and treatment under Marchman Act, documentation, training, and review. The plan designates a local receiving facility for emergency transports. The plan is reviewed annually and was last reviewed October 12, 2020 by the new acting facility administrator.

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 has not had any Baker Acts or Marchman Acts during the annual 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 licensed medical doctor who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida. The designated health authority (DHA) has a specialty in internal medicine with a license which expires January 31, 2022. The program does not utilize a physician assistant or an advanced practice registered nurse. The DHA does not delegate clinical duties. A review of sign-in/out sheets for the previous six months, with no exceptions. The DHA is on-call twenty-four hours a day, seven days a week. If the DHA is on vacation, a DHA from another program of the same provider is planned to fill in. At the time of this annual compliance review, there had not been a need for this to occur. The back-up DHA is an osteopathic physician with a license expiring March 31, 2022. The DHA is responsible for communication with program staff regarding youth medical needs and having availability for consultation by electronic means twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. An interview with DHA confirms he performs Comprehensive Physical Assessments, periodic evaluations, sick call follow-up if needed, referrals, review off-site care visits, and develops policies and procedures. Along with the health services administrator (HSA), who is a registered nurse (RN), the program has two additional full-time registered nurses and one pro re nata (PRN) nurse.

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

The program has facility operating procedures (FOPs) for all health-related procedures and nursing protocols at the program. The FOPs were signed by the designated health authority (DHA) and the facility administrator (FA) April 24, 2020. An annual review of the FOPs and nursing protocols was completed on April 24,2020, however, the DHA's signature was not documented on the signature form for one FOP. One FOP (4-10a) was revised September 25, 2020, and was signed by the DHA, but not by FA or reviewed by nursing staff. This was corrected during the annual compliance review. All newly hired nursing shall staff receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, given by a registered nurse. The orientation documentation includes a job-specific training plan with on the job training.

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

Seven youth healthcare records were reviewed for Authority for Evaluation and Treatment (AET) forms. Six of the seven youth records had a signed AET filed in the record with the word "copy" legibly stamped on it. The AETs are valid for as long as the youth are in the program or until the youth's eighteenth birthday. The remaining youth was in the care of the Department of Children and Families and had a current court order filed in the record.

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

Seven youth healthcare records were reviewed for parental notification and consent. Six youth were applicable for parent/guardian notification. Six of the seven youth were applicable for notification of over-the-counter medication beyond those covered by the Authority for Evaluation and Treatment (AET) form. Five written parental notifications for the vaccinations were sent to the parents/guardians, with no response. Verbal parental notifications were documented in the progress notes for each youth. Four youth required notification be sent for emergency care. Written notification was sent regardless of telephone notifications. Telephone conversations were documented. One youth required parental notification regarding psychotropic medication. Verbal consent was documented followed with written notification. Each of the verbal consents were witnessed by another staff member, as documented in progress notes. The written notifications included the Clinical Psychotropic Progress Note (CPPN). The remaining youth was in the care of the Department of Children and Families. Reviewed documentation confirmed the court authorized all treatment and procedures, including consent prior to administering newly prescribed or changes to psychotropic medications. Seven youth healthcare records were reviewed for vaccination verification. All seven records had documentation the vaccinations were verified on each youth's date of admission. The program reviews the Florida Shots website and utilizes the Immunization Tracking Record. An interview with the nurse confirmed the immunizations are reviewed the date of admission.

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.	

Seven youth healthcare records were reviewed for healthcare admission screenings. All seven records had documentation indicating the Facility Entry Physical Health Screening (FEPHS) form was completed on the date of admission. All seven screenings were completed by a registered nurse. None of the seven records were applicable for a FEPHS re-screening due to changes in the youth's physical custody; therefore, two additional applicable records were reviewed. Each applicable youth record contained a new FEPHS rescreening form completed upon the youth's return to the program. Both rescreenings were completed by a registered nurse.

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.	

Seven youth healthcare records were reviewed for youth orientation to healthcare services/health education. All seven records had documentation indicating each youth received general care orientation upon admission to the program. The program's policy for healthcare education includes topics including access to medical care, how to access sick call, what constitutes an emergency and when to notify staff, medication process, the right to refuse care, what to do in the case of a sexual assault, and the non-disciplinary role of the healthcare providers. Each youth signed a document confirming a healthcare orientation was conducted.

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 designated health authority (DHA) or designee is notified when youth admitted to the program require emergency care or routine notification is accordance with the Department requirements. A referral to the DHA shall be made for youth who are admitted with known or suspected chronic conditions not requiring emergency treatment on admission. Seven youth healthcare records were reviewed for DHA admission notification. Three youth were known to have a suspected chronic condition upon admission. None of the youth were identified as in-need of emergency care. All seven records documented the DHA was notified by telephone of each youth's admission during intake. Notification to the DHA was documented on each youth's progress notes in the healthcare record.

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

Seven youth healthcare records were reviewed for Health-Related History (HRH). All seven records documented the HRH was completed on the youth's date of admission by a registered nurse. All records indicated the HRH was reviewed by the designated health authority (DHA) with the checkbox on the Comprehensive Physical Assessment (CPA). Each record documented the HRH was completed before or at the same time as the CPA. An interview with the nurse confirmed the HRH is completed at the time of admission by the admitting registered nurse.

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

The program has a policy and procedures for appropriately documenting the Comprehensive Physical Assessment (CPA). The program has a policy and procedures for Tuberculosis Screening. Seven youth healthcare records were reviewed for a CPA and Tuberculin Skin Test (TST). All records contained a new CPA completed within seven calendar days of the youth's admission utilizing the Department's CPA form. The CPAs were completed by the designated health authority (DHA). All sections of the CPA were completed. All seven youth refused the genital exam and each youth signed the CPA as a refusal. The Department's Problem List was updated, for each youth, as applicable. A current TST was documented on the CPA and the Infectious and Communicable Disease (ICD) form. All seven youth records had documentation indicating the Tuberculosis Symptom Screening (Tier I) was completed on the Facility Entry Physical Health Screening (FEPHS) form. None of the youth required chest x-rays as a result of the TST screening. An interview with the nurse confirmed each youth is administered a TST annually.

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.	

Seven youth healthcare records were reviewed for sexually transmitted infection (STI) and human immunodeficiency virus (HIV) screenings. All seven records documented the youth were screened and evaluated for STIs. Each youth was referred to the designated health authority (DHA) who ordered testing for all seven youth. There was documentation reflecting testing was completed for all seven youth. All testing results were documented on the Infectious and Communicable Disease (ICD) form and all seven youth had the results filed in the lab section of the record. Each record had documentation on the STI screening form and progress notes of the referral for testing. Each youth was offered testing for HIV screening. Four youth consented to HIV testing. Three youth did not consent to testing. A certified HIV counselor conducted the testing for the four youth. Documentation of pre- and post-testing counseling was documented on the Health Education Record for all four youth. The program has an agreement with the Marion County Health Department (MCHD) to conduct testing. The agreement with the MCHD requires the test results to be maintained at the health department. The MCHD agreement indicates the youth and DHA will be notified if the results are positive.

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.	

Seven youth healthcare records were reviewed for the Sick Call Process. Five youth records were applicable for sick call requests. Six sick call events were reviewed. None of the youth presented with similar sick call complaints three or more times within a two-week period. The youth completed Sick Call Request forms which were placed in a secure location inaccessible to youth and then provided to the nurse. The completed Sick Call Request forms were filed with the progress notes in the youth's healthcare record, in reverse chronological order. Sick call is conducted daily, as required by the contract. The sick call forms documented the youth's vital signs, treatment, education, and follow-up. Each sick call was documented on the Sick Call Index and Sick Call Referral Log. Sick call is conducted twice daily by a registered nurse. Youth privacy is ensured during sick call encounters. Sick Call Request forms were observed located in the youth dorms. A sick call was observed with the youth's permission to ensure confidentiality was maintained. The youth was brought to the medical clinic by the floor staff who was Protective Action Response (PAR) certified. The nurse identified herself and clarified why the youth was there. The youth signed the sick call form prior to the exam. The youth was seen in an examination room, separated from the other youth. The registered nurse conducted the exam. Four of the seven interviewed youth stated they can see a nurse immediately when a sick call request is submitted. Two youth stated within one day, one stated never. All seven interviewed staff stated the nurse conducts sick call.

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

The program has a policy and procedures regarding episodic and emergency care. Emergency medical and dental care are available twenty-four hours a day. Seven youth healthcare records were reviewed for episodic care. The seven had a total of twenty-two episodic care incidents. None of the episodic care incidents were conducted by non-healthcare staff. On-site care by the nurse was documented with standard narrative charting which included the date/time of the episodic care, nature of the complaint, over-the-counter medications given, treatment provided, referral for off-site care if needed, and education/instruction to the youth if needed. Twenty of the twenty-two episodic care incidents were documented on the episodic care log, as required. The remaining two episodic care incidents were not documented log.

The program has two first aid kits located inside in each of the two dorms. There are three first aid kits for the transportation vehicles; one car and two vans. The program has three suicide response kits, one located in master control, and one for each dorm. Three first aid kits were observed to be stocked with the contents listed in the policy and approved by the designated health authority (DHA). No expired contents were found. There was documentation the first aid kits were monitored monthly and replenished, as needed. The program has four automated external defibrillators (AEDs) with one in each dorm, one in master control, and one in the medical clinic. The instruction guides were attached to the AEDs. There was documentation indicating the AEDs were checked monthly by the nursing staff. The batteries expire March 2028 and the pads expire March 2024. A test was conducted on each AED. Emergency medical drills were conducted at least quarterly on each shift for each of the three quarters reviewed. Cardiopulmonary resuscitation (CPR) was demonstrated on each shift, each quarter. A list of emergency numbers is maintained and are inaccessible to youth. All staff received training on the use of an epinephrine auto injector during pre-service training. All licensed healthcare staff maintain current CPR and AED certifications. All seven interviewed youth stated they can see a doctor if needed. Three of the seven youth stated they could see a dentist if they had tooth pain. Four of the seven stated they could not see a dentist. Seven interviewed staff stated they would notify the supervisor or master control to call 9-1-1, if a youth had a medical emergency, as the direct-care staff do not have access to a phone while working.

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.	

Four of the seven reviewed youth healthcare records were applicable off-site care. Parent/guardian notifications were documented for all events. The Summary of Off-site Care form was utilized and filed in each record. When applicable, discharge and other documents were filed in the youth record. The designated health authority (DHA) reviewed and initialed all off-site care findings, instructions, and information. When applicable, follow-up testing, referrals, and appointments were tracked for timely follow-up care.

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.	

Three of the seven reviewed youth healthcare records were applicable for youth with chronic conditions. All three youth had asthma, were taking medication on an ongoing basis, had a medical grade between two and five, and were placed on the chronic condition list. Reviewed documentation confirmed each youth had a periodic evaluation completed at least every three months. Each youth had a specialized treatment plan. Periodic evaluations were tracked on the Department's Chronic Physical Health Conditions Roster form. All youth records had periodic evaluation documentation. The periodic evaluation was conducted prior to the renewal of prescription medication which had expired. The periodic evaluations were documented in the progress notes in each record. None of the youth records reviewed were applicable for off-site care, however, the program has a policy and procedures in place for youth who are seen for off-site care to ensure the designated health authority (DHA) will follow-up with the youth upon return to the program and sign off on documents. There were no indications of lapses in care or missed periodic evaluations. The Department's Problem List for each youth was updated, as applicable. An interview with the nurse confirmed the medical clinic maintains a tracking log for the DHA to conduct periodic evaluations.

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.	

There are no standing orders, emergency treatment orders, or pro re nata orders for psychotropic medications. Three of the seven reviewed youth healthcare records were applicable for admission into the program with prescribed medication. All three applicable youth had medications verified prior to admission to the program. Documentation of prescription verification was found in each youth's progress notes and utilized the prescription medication verification checklist. The designated health authority (DHA) was contacted to obtain the order to continue current medications for each youth. All medications had a current, valid order. If there were any changes with the prescribed medications, the DHA placed an order on the Practitioner Order form. Over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form were administered according to approved protocols. The standard Department Medication Administration Record (MAR) is used to document all medication and treatment clearly indicated medication start and stop dates. Staff initialed each administered medication entry. There were no lapses or errors in medication administration. At a minimum, the nursing staff documented side effects weekly on the MAR. Refusals were clearly documented on the MAR, as well as a separate refusal form. Medication administration was observed. Medication administration is the responsibility of the nurse during the administration. Youth were escorted to the medical clinic by direct care staff. Youth approached the nurse individually, at a window outside the clinic. There were no other youth at the window at the same time. The Six Rights of Medication Administration were verified. Nursing staff observed youth to ensure medication was swallowed. There was no pre-poured medications. All medications were in a separate locked area designated for medication storage, inaccessible to youth. All non-controlled medications, prescribed and over-the-counter, were stored in a separate, secure, locked area inaccessible to youth. Narcotics and other controlled medications were stored behind two locks, in a separate locked box inside the locked medication cart.

Medications were stored separately by type or form. Medications requiring refrigeration were stored in a secure refrigerator used for medication only. Syringes and sharps were secured in a cabinet inaccessible to youth. The medication cart was observed to be clean, organized with stock items separate from youth-specific medications.

The program has a policy and procedures for the disposal and destruction of expired or discontinued medications. Non-controlled medications are destroyed in the presence of two registered nurses. Controlled medications are destroyed with the pharmaceutical representative and the health services administrator. Five youth of the seven interviewed youth stated medications are given to them by the nurses. The remaining two youth did not take medication. All seven interviewed staff stated nurse provides medication or the trained supervisor, who has been training in administering medication, when there is not a nurse on-site.

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.	

Any medical equipment classified as sharps are securely stored and inventoried utilizing a perpetual inventory, descending in count as each sharp is utilized and disposed. All medications are identified and secured in a locked area designated for storage of medications. Injectables, topicals, drops, liquids, and over-the-counter (OTC) medications are stored separately. Perpetual daily inventories for medication utilization for youth, all sharps, and OTC medications were maintained. Controlled medications are stored behind two locks, in a separate locked box inside the locked medication cart. Shift-to-shift inventory counts were conducted on controlled substances and documented on the youth's Individualized Controlled Medication Inventory Record. The number of dosages remaining after each administered dosage was documented on the youth's Individualized Controlled Medication Inventory Record. The program has a policy and procedures for the disposal and destruction of expired or discontinued medications. Supervisory level, non-healthcare staff trained in the delivery and oversight of medication self-administration may assist when licensed staff are not on-site. Inventory counts were conducted on three sharps and three prescribed medications which revealed no discrepancies. Two of the three OTC medications had discrepancies. A count for an antihistamine was documented as ninety-one and the count completed was ninety. An anti-inflammatory medication documented count was 118 and the completed count was ninety-one. There are policies and procedures in place to resolve discrepancies. An interview with the health services administrator confirmed the procedures for maintaining all medication and sharps inventories.

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 policy and procedures regarding infection control. The program has infection

control procedures in place to include prevention, containment, treatment, and reporting guidelines related to infectious diseases, as according to the Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) guidelines. The infection control procedures include common diseases of childhood, self-limiting episodic contagious illnesses, viral or bacterial infectious disease, tuberculosis, hepatitis, blood-borne pathogens, outbreaks or epidemics, lice or scabies, methicillin-resistant staphylococcus aureus (MRSA), foodborne illnesses, bio-terrorist agents, and chemical exposures in the workplace. Hepatitis B immunizations are available for staff upon hiring. Staff have access to protective equipment.

There were forty instances in which local county health department, CDC, or Central Communications Center (CCC) were notified regarding youth testing positive for COVID-19, and reported within the time frame. There were forty instances involving the quarantining of at least ten percent of the population or more of youth or staff. All youth were quarantined, Health Department, and CDC guidelines were followed, as well as the infection control plan. The policy includes a comprehensive process for needle stick post-exposure evaluation. There were no incidents where youth or staff experienced a facility occupational exposure. The program has an exposure control plan written in accordance with OSHA standards. The exposure control plan is available to all staff. The exposure control plan included risk of assessment and methods of compliance. An interview with the facility administrator confirmed a copy of the exposure control plan is maintained in master control, medical office, dietary office, and maintenance. Seven pre-service training records were reviewed. All seven staff had training for the exposure control and infectious control plans.

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

This is a male program; therefore, this indicator rates as non-applicable

4.19 Licensed Medical Staff (Critical)	Satisfactory Compliance
The program shall provide access to prenatal care for all pregnant youth. Health Education shall be provided to both youth and staff.	

The designated health authority (DHA) is clinically responsible for all healthcare services provided to youth at the program. Daily clinical care shall be performed by licensed medical staff according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according Department Rule as well as facility operating procedures and nursing protocols approved by the DHA. All nurses have clear and active licenses, which were verified with the Florida Department of Health Medical Quality Assurance. Nurses practice within the Florida Nurse Practice Act and the applicable Florida Board of Nurse Rules (Chapter 464, F.S. and Division 64B). The program has on-site coverage by registered nurses. The program does not utilize licensed practical nurses. The program has a registered nurse (RN) who serves as the clinic manager/health service administrator, two fulltime RNs, and a pro re nata RN, as required by contract. All nurses have current cardiopulmonary resuscitation (CPR) certifications.

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

The program requires a staff-to-youth ratio of one-to-eight during daytime activities, and one-to-twelve when youth are asleep. Observations of daily activities were made all four days of the annual compliance review. Observations of school, recreation, meals, breaks, and line movements confirmed staff were actively supervising youth within ratio. Positive interactions between staff and youth were witnessed. When asked how many youth the staff was supervising, each staff responded accurately with the number of youth under their supervision. The program has a full schedule of activities planned. The schedule was observed posted in each of the dorms. Youth were observed participating in the full schedule of activities. Staff were closely monitoring youth behavior and changes in behavior, as well as consistent application of the behavior management system by staff. Staff account for youth under their supervision at all times. Youth were observed accounted for and accompanied by staff at all times. Video review reflected staff observe youth while in their sleeping rooms. All seven interviewed staff explained the process when a count cannot be reconciled, including notifying the supervisor, to locking down the facility and searching for youth.

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

The program has a behavior management system (BMS). There is an agreement between the program and the school related to the BMS reflecting a joint plan for BMS during school hours. The BMS is clearly written in the youth handbook and on postings throughout the facility. A review of seven youth records confirmed the program's BMS is provided to the youth during orientation. Rules governing conduct and positive and negative consequences for behaviors are documented in the youth handbook. The program's BMS, called the iChoose System, includes the following: maintain order and security, promote and protect youth rights, positive and negative consequences, constructive disciplinary actions, opportunities for positive reinforcement, recognition of accomplishments and positive behaviors exceeding a four-to-one ratio, promote socially acceptable means for youth to meet their needs, process for explaining to youth the reason for any sanction imposed, youth have the opportunity to explain their behavior, opportunity for staff and youth to discuss the impact of the behavior on others, reasonable reparations for harm caused to others, discussion of alternate behaviors, promotion of positive dialogue and peaceful conflict resolution, separation of youth from population is minimized, coordination with any individual behavior plan, and consistent implementation and treatment through oversight. The program's BMS does not include increasing length of stay, denial of

basic rights or services, group punishment, or disciplinary confinement. The BMS provides for a variety of rewards and incentives. All seven interviewed staff stated things cannot be taken away from youth as a consequence. None of the seven interviewed youth responded their basic rights were taken away as a consequence. One responded they can lose point store as a consequence, and one reported a reduction of points.

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

The program has a policy and procedures which reflects protocol where staff are provided feedback regarding the implementation of the behavior management system (BMS). A sample of position descriptions was reviewed which specified required qualifications of staff whose job functions includes implementation of the program's BMS. The BMS does not include an increased length of stay, denial of a youth's basic rights or services, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement. Seven reviewed staff training records contained documentation indicating the staff received training on the program's BMS. Six of seven interviewed youth indicated supervisors provide feedback regarding the implementation of the BMS daily during meetings or individually. One staff indicated supervisors provide additional training on the BMS. Six of seven interviewed youth rated the BMS as good, and one rated it as fair. Each of the youth reported staff are consistent in the use of rewards. All youth stated youth are never allowed to punish other youth. The facility administrator indicated the program uses a Positive Performance System, called "iChoose," as the BMS. iChoose is an incentive-based system and allows the youth to know their status in the program daily along with providing incentives for daily achievements. The system consists of five levels in which the youth must petition their peers and treatment team to advance from level to level. All seven youth knew the levels of the BMS.

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

The program has 140 cameras providing video coverage of the facility, all of which were operational at the time of the annual compliance review. The video recordings are stored for thirty days. Ten-minute checks were reviewed for three different days to include all shifts and each dorm. Checks were documented and observed occurring between eight and ten minutes. Staff were observed conducting checks in a manner ensuring the safety and security of youth. Ten-minute checks were documented in real time and the staff initials were documented All

seven interviewed reported checks are completed every eight minutes when youth are in their room for sleeping.

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

The program has a policy and procedures which address youth census, counts, and tracking. Counts were observed during the annual compliance review and no issues were found. A review of logbooks revealed the program conducted counts at the beginning of each shift, after each outdoor activity, and during emergency situations. Formal scheduled counts were conducted hourly and were listed separately in the logbook. All seven interviewed staff explained if there is a discrepancy, a recount is conducted.

5.06 Logbook Entries and Shift Report Review	Satisfactory Compliance
The program maintains a chronological record of events, incidents, and activities in a central log-book maintained at master control, living unit logbooks, or both, in accordance with Florida Administrative Code. The program ensures direct care staff, including each supervisor, are briefed when coming on duty.	

Logbooks were found to be bound with numbered pages. Observations confirmed all entries were in ink with no erasures or white-out areas. No logbook entries were obliterated or removed. All errors were struck through with a single line and dated and initialed by the staff correcting the error. All entries included the date and 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 documents emergency situations, incidents, including the use of mechanical restraints, special instructions for supervision and monitoring of youth, population counts at the beginning and end of each shift, and any other population counts conducted during a shift, perimeter security checks and other security checks conducted by direct care staff, transports away from the facility, including the names of the staff, youth involved, and the destination, requests by law enforcement to access any youth, admissions, transfers and releases, and internal incidents reported to the Florida Abuse Hotline and/or the Central Communications Center in the central logbook maintained by master control. Shift reports were reviewed which summarized the events, incidents, and activities documented in the program's central logbook. The program supervisor verbally briefs oncoming staff about the contents of the

logbook, or staff review the logbook themselves. Oncoming staff signed and dated the shift report portion to document acknowledgement of its contents.

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

The program has a policy and procedures regarding key control which includes the control and use of keys. The policy includes 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, and reporting and replacement of damaged keys. Distribution and collection of keys by master control was observed. The key inventory was reviewed, and the inventory matched the actual key rings in use. The key storage area was secure. An interview with the master control operator indicated the process for restricting usage of keys, such as medical, youth and staff records, and youth property, is keys are position-specific and kept on assigned rings. The daily tracking and reconciliation of keys is maintained on the key control log. There have been no incidents of missing or lost keys in the last six months. All seven interviewed staff indicated staff keys are given to master control upon entry, and program keys are assigned to staff. Six staff reported personal keys are securely stored, and a chit is provided to visitors, and the facility is searched if keys are missing. Five staff explained tracking keys is completed utilizing a key log, visitor keys are given to master control upon entry, youth do not have access to keys, and staff are to notify master control of missing keys. Five staff indicated youth are searched when there is a missing key and keys are replaced, if damaged. Three sets of keys were selected at random and compared to the log and attached chit. All three had the recorded number of keys as displayed on the chit and in the key log.

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

The program has a system in place to prevent contraband from entering the facility. This system includes the program defining what items or materials are considered contraband, as well as exemptions. Youth are provided with a list of contraband which include sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, electronic equipment or devices, lighters or matches, any intoxicating beverages, metals, personal cell phones, unauthorized money, and non-facility issued keys. Youth are informed of consequences if found with contraband. To prevent contraband, searches are conducted of the physical plant, facility grounds, youth, incoming mail, and outgoing mail. The program's policy and procedures address any staff who is found in possession of contraband will be subject to disciplinary action up to and including dismissal, and law enforcement shall be contacted if any item found would be considered illegal. The program maintains a log related to contraband searches. When contraband is discovered, it is listed as well as the disposition. The facility administrator reported any youth, staff, or visitor having contraband shall be dealt with immediately to ensure the safety and security of the program. All discovered contraband shall be destroyed, disposed of, sent to the youth's home, or kept as evidence to submit to law enforcement, as indicated for illegal contraband. Youth are made aware of contraband discovered and plans for disposition. Possession of contraband presumed illegal shall require notification to law enforcement, establishment of chain of custody to include documenting when, where, and who discovered the item. If the nature of the contraband requires notification to law enforcement or filing criminal charges the contraband shall be considered evidence and must not be altered in any way. Discovery of illegal contraband shall require an internal incident report and reporting to the Central Communications Center.

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

The program has a policy and procedures related to searches and full body visual searches. Youth searches were observed before and after groups, before and after education, and before and after recreation. Two transports were observed by video recording. During the searches,

youth were treated with dignity and respect to minimize the youth's stress and embarrassment, and the search was conducted by the appropriate number of staff and gender. Searches were observed to be thorough and staff provided instructions to the youth and explained the reason and extent of the search to the youth. Youth searches were conducted according to the Protective Action Response training manual. All seven interviewed youth reported searches occur after returning from off-campus activities, outdoor activities, when items are missing, after visitation, and after meals. Each of the seven interviewed staff reported youth searches are conducted before any 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 three vans which are used to transport youth. Each vehicle had documented maintenance records and the vehicles were always secured. Invoices from an automotive shop reflected all three vehicles received an annual safety inspection and any deficiencies were corrected. A check of personal vehicles and program vehicles reflected the vehicles were locked when not in use. The vehicles were each equipped with a fire extinguisher. There are approved first aid kits staff take during transports. The vehicles have a seat belt cutter, window punch, and the appropriate number of seat belts. Youth are not attached to any part of the vehicle by any means other than proper use of a seat belt. The doors to the youth passenger area cannot be opened from the inside if the childproof setting is used. Transportation staff indicated seatbelts must be used during transports.

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

The program has a policy and procedures which follows the requirements of the Department relating to transportation of youth and driver eligibility. The program issues a cell phone to transporters to use while on transports. During transports, a one-to-five staff-to-youth ratio, not to include the driver, is used. During transports, there is one staff of the same gender of the youth transported. A check of personal vehicles and program vehicles found the vehicles were locked when not in use. Youth and staff wear seat belts during transports, and youth are not attached to any part of the vehicle by any means other than the proper seat belt. All staff operating a program vehicle have a current driver's license. There was no evidence to reflect staff leave youth unsupervised in vehicles. Youth are not permitted to drive program or staff vehicles. Seven interviewed staff reported staff are provided a cell phone to use during transport. All staff reported program vehicles are searched before transports, and staff are not allowed to use personal vehicles to transport youth.

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

The program has a policy and procedures outlining the weekly safety and security inspection process which includes the following: the chief of security is responsible for conducting the weekly security audits and safety inspections, the development and implementation of corrective actions warranted as a result of safety and security deficiencies found during any internal or external review, audit, or inspection, and an internal system to verify the deficiencies are corrected and existing systems are improved or new systems are instituted, as needed, to maintain compliance. Weekly safety and security audit documents were reviewed and reflected the audits were completed every seven days. The facility administrator confirmed the program utilizes a weekly safety and security audit tool to monitor and track safety and security deficiencies.

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

The program has facility operating procedures which addresses the issuance, inventory, and control of equipment and tools. Observations reflected tools were securely stored when not in use. All tools were marked for easy identification. Documentation reflected tools were inventoried prior to being issued for work and inventoried following work activities. All tools were inventoried daily, such as sharp-edged, pointed tools (except on days not used). A monthly inventory of tools class B tools occurs. Machetes, bowie knives, or other long blade knives are prohibited. There was documentation to reflect procedures for missing or lost tools. There were no instances of dysfunctional tools which needed to be disposed of and replaced. Training documentation for seven staff and seven youth reflected each were trained on the intended and safe use of tools, and a risk assessment is conducted for youth prior to tool use.

5.14 Youth Tool Handling and Supervision	Satisfactory Compliance
There shall be procedures to ensure youth use tools safely and are supervised appropriately in order to prevent injuries to the youth, other youth, and staff.	

The program has a policy and procedures which addresses supervision when youth use tools and issuing tools to youth and staff which includes an assessment to determine youth's risk to self and others. Staff-to-youth ratios are maintained at one staff to five youth during activities which involve tools. Staff and youth were observed during cleaning activities which confirmed the program maintains the appropriate ratio of one staff to five youth, searches of the youth occur, and tools are distributed and collected at the completion of the work project.
A review of seven youth records confirmed each youth had a risk assessment completed permitting the use of tools. Seven youth and seven staff were interviewed, and each reported the youth are allowed to use brooms and mops.

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

The program has a policy and procedures regarding outside contractors. Sign-in sheets and instruction sheets for outside contractors were reviewed. The guidelines for external worker tools include the following: tools are checked upon arrival and departure, tool restrictions while in the program, youth are restricted from the work area, and missing tool follow-up. Project invoices submitted to the program by the vendor were reviewed. It was determined the date the project was worked on matched the sign-in sheets and the program inventoried the tools when the vendor arrived and left. The program's maintenance supervisor is responsible for providing approval for tools/items being brought on site.

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) reflects fire drills are to be conducted once a month on each shift. Documentation reflected the program conducted practice drills and is prepared for immediate implementation or mobilization of the plans whenever an emergency or disaster situation necessitates. Documentation of drills confirmed at least one monthly drill on each shift covered the following topics: fire, medical, bomb threat, riot/disturbance, chemical spill, and severe weather. Documentation for all drills documented the types of drills, dates and times, participants, brief scenarios, and findings and recommendations. Unannounced fire drills were conducted in accordance with the program's COOP, under varied conditions, and across all shifts. Fire evacuation routes and egress plans were observed posted throughout the program. Fire extinguishers were inspected annually, with monthly checks completed by maintenance. The facility administrator stated fire drills are conducted monthly on each shift. COOP drills were conducted quarterly on each shift. All seven interviewed youth reported knowing what to do in the event of a fire. One youth reported fire drills occur monthly. Each of the seven interviewed staff reported participating in a fire drill, six stated weather drills, five reported escape and major disturbance, four reported bomb threat and chemical spill drills, three stated hostage situation and flooding, and two others reported medical, suicide, COOP, and mental health drills.

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

The program has a Continuity of Operations Plan (COOP) which is kept in master control. The program posts a notice which identifies the location of the plan for staff. The COOP was reviewed on March 8, 2020. The plan addresses alternative housing plans approved by the

North Residential Regional Director for the Department on March 31, 2020. The program's Disaster and COOP are a combined plan. Observations made of the program's provision of equipment and supplies required for continuous operation and services during emergency or disaster situations. The facility administrator indicated the COOP is located in master control. The program's COOP includes fire and fire prevention and evacuation, severe weather, program disturbances, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The program maintains critical identifying information for each youth in an administrative hard-copy file easily accessible and mobile in the event of an emergency situation resulting in the program relocating quickly or in the event needed information cannot be accessed electronically. The administrative hard-copy file for each youth in the program contained all required information. Emergency supplies were observed in a locked room adjacent to the kitchen.

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

The program has a policy and procedures regarding the storage and inventory of flammable, poisonous, toxic items, and materials. Flammable, poisonous, and toxic items were observed securely stored in the maintenance building, outside the campus perimeter fencing. The items were stored in secure areas inaccessible to youth. Documentation indicated inventories were maintained for all flammable, poisonous, and toxic items. A review of the inventory reflected there were no missing items or additional items which were not on the inventory. The inventory matched the actual items within the program. The program maintains a list of positions, titles, or functions authorized to handle these items. Safety Data Sheets (SDS) were compared with the inventory and all materials on-site had an SDS.

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

The program has a policy and procedures regarding youth handling and supervision of flammable, poisonous, toxic items, and materials. The program maintains strict control of these items. Youth do not use, handle, or clean-up dangerous or hazardous chemicals. Youth do not clean, handle, or dispose of any person's bio-hazardous material, bodily fluid, or human waste.

There is restricted access to areas where items are used or stored. Youth were observed during daily cleaning activities which reflected staff sprayed the cleaner and youth used cleaning tools to wipe it. The program's preventive maintenance checklist was reviewed to ensure maintenance schedules and repairs were conducted, as outlined in Florida Administrative Code. All seven interviewed youth reported they do not handle chemicals.

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

The program has a policy and procedures regarding the disposal of flammable, toxic, caustic, and poisonous items. The program identifies staff positions authorized to dispose of these items, the physical plant manager. The physical plant manager received training for disposing of hazardous and toxic materials. Disposal procedures are in accordance with Occupational Safety and Health Administration (OSHA) Standards 29. Since the program opened, there have been no instances in which these types of materials were disposed. Liquid wastes such as dirty mop water, or unused beverages from work details is disposed of in the plumbing drains. Kitchen liquid waste, except grease, is disposed of in the kitchen. Grease is placed in a separate container for disposal. There have been no instances of chemical spills. The maintenance staff are responsible for the safe and lawful disposal of these items. Only maintenance or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste, shall be responsible for disposing of these items. The facility administrator reported disposal of hazardous chemicals is completed by contacting a waste facility, which will come out to the facility and remove the hazardous materials.

5.21 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Satisfactory Compliance

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures related to visitation, youth correspondence, and use of the telephone. The posted visitation schedule was observed. A review of the visitation log and schedule, telephone log and schedule, and mail log were conducted. Alternate visitation arrangements were made available utilizing Zoom meetings due to the COVID-19 pandemic. When in-person visitation was restarted, visitation was arranged by appointment. Youth are given the opportunity to communicate with family members by mail and telephone. The program conducts searches of incoming mail in the presence of youth or youth representative and searches outgoing mail. All seven interviewed youth reported they have been given the opportunity to communicate with family members by mail or telephone or at 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 currently does not utilize controlled observation; however, controlled observation was utilized through October 2020. Since controlled observation was used during the annual compliance review period, three instances were reviewed. The rooms used for controlled observation were more than thirty-five unencumbered square feet, with metal doors, shatter resistant windows, inaccessible vents, recessed lights, flame retardant mattresses, and no electrical outlets or switches. Documentation reflected youth and rooms were searched prior to putting youth in controlled observation.

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

The program maintains a written policy and procedures for controlled observation. The program has six documented instances of controlled observation. A review of three instances reflected non-physical interventions were not effective. In each incident, the youth was exhibiting behaviors indicative of a mental health crisis, the youth were placed in controlled observation by supervisory staff, and the youth displayed violent, active aggression. The rooms and youth were searched by a staff of the same gender prior to placement. Youth were made aware of the reason for placement and the expected behavior for removal. In all three instances, a healthcare professional completed the health status checklist. The facility administrator (FA) granted an extension over two hours in all three incidents. Documentation reflected checks were completed every fifteen minutes, as required. Staff completed all the required documentation, and the FA provided written approval before each youth was released from controlled observation, determining the youth's behavior was no longer a threat. The FA reviewed all controlled observation reports within fourteen days, as required.

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

The program maintains a written policy and procedures for the use of controlled observation safety checks and releasing youth from controlled observation. A review of three Controlled Observation Safety Check forms was conducted. Each reviewed Controlled Observation Report indicated the staff who placed the youth in control observation completed the first page of the Controlled Observation Report which was submitted to a supervisor. Each of the Controlled Observation Reports documented staff conducted safety checks at least every fifteen minutes. Each entry documented the time, a code to explain the youth's behavior at the time of each observation, and the staff's initials who observed the youth. All three reviewed reports reflected the facility administrator's (FA's) authorization of the youth's release from controlled observation was based upon the determination the youth's verbal and physical behavior was no longer an imminent threat to himself or others. Each report was reviewed and approved by the FA within fourteen days of the youth's release from controlled observation and determined the placements

were warranted and each was handled appropriately. Documentation showed an in-house alert was not warranted for the three youth when they were released from controlled observation.