STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Center For Success and Independence - Ocala

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

Review Date(s): October 8-11, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Amy Hutto, Office of Program Accountability, Lead Reviewer (Standard 1)
Meeta Amin, Juvenile Probation Officer Supervisor, Circuit 5, Department of Juvenile Justice, Interviews
Phil Amorgianos, Facility Administrator, TrueCore Behavioral Health Solutions, Standard 5
Renette Crosby, Education, Department of Juvenile Justice, Standard 2
TiAnna Greene, Juvenile Probation Officer Supervisor, Circuit 5, Department of Juvenile Justice, Standard 2
Katina Horner, Regional Monitor, Department of Juvenile Justice, Standard 3
Jennifer Schad, Regional Monitor, Department of Juvenile Justice, 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 8-11, 2019

MQI Program Code: 1449
Contract Number: 10575
Number of Beds: 72
Lead Reviewer Code: 157

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.01 Initial Background Screening *	1.07 Pre-Service/Certification Requirements *
1.13 Gender-Specific Programming	
3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	
3.07 Treatment and Discharge Planning *	
5.26 Safety Planning Process for Youth	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Limited
1.02	Five-Year Rescreening	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 *	Failed
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	Limited
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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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 the following services: substance abuse overlay services (SAOS) and mental health overlay services (MHOS). In addition, the program fosters each youth by providing the following delinquency interventions and treatments: therapeutic services to address behavioral issues, mental health and substance abuse overlay services. In addition, the program provides Trauma Focused-Cognitive Behavioral Therapy, Seven Challenges, Skillstreaming the Adolescent, Young Men's Work, Moral Recognition 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 resource 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, assistant clinical director, contracted psychiatrist, contracted advanced practitioner registered nurse, five master's-level therapists, a recreational therapist, 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), two additional full time registered nurses, and four pro-re-nata (PRN) nurses. The program also 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 and kitchen, four portables which serve as classrooms, and a building which houses medical as well as two conference rooms. The program has 132 operating security cameras providing coverage. At the time of the annual compliance review, the program had fourteen vacant positions; one community liaison, one licensed therapist, two shift supervisors, one transporter, one physical plant worker, one youth care worker II, two youth care worker III, two master control operators, one vocational instructor, and two PRN nurses.

Strengths and Innovative Approaches

- The program is currently developing a Horse Care program and it has already proven to be effective in changing the lives of youth at the program. Currently, the program has all the fencing required completed, purchasing orders have been approved for training materials and tools as the program prepares for the installation of a barn. Each youth will have the opportunity to participate in the Horse Care program. 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)	Limited Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. A contract provider may hire an employee to a position which requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible and the employee demonstrates he or she exhibits no behaviors which warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The program has been open less than a year. The contract between the Department and provider was executed on December 18, 2018. All seventy-eight employees were reviewed for initial background screening. Eight employees did not have a background screening completed prior to their date of hire. The program began accepting youth on January 28, 2019; all eight employees had a completed background screening prior to this date. Twenty-five employees did not reflect the criminal history was reviewed. Review of employee records also revealed there are twenty-eight employees who did not complete a pre-employment assessment tool. The provider's contract reflects the provider shall perform pre-employment assessments using a suitability assessment tool for all prospective employees providing direct care to youth prior to hiring. Additionally, the program's facility operating procedure 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 provider), 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.

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 procedure which indicates all employees will be rescreened 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 five-year rescreening.

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

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

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

The program has a policy and procedures regarding abuse free environment. Seven staff personnel records were reviewed and each reflected staff adhere to a code of conduct as indicated by the employees' signature. The Florida Abuse Hotline and Central Communications Center (CCC) numbers were observed posted throughout the program. The program's abuse reporting policy documents the steps to report abuse. These steps include staff shall provide telephone access to report allegations of abuse, the shift supervisor must be notified immediately of a youth's request, 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 name and number and document on the internal incident report. In the event a youth changes his mind and no longer wants to make the call, ensure the youth's refusal of the call is documented in the facility logbook and on the internal incident report, the shift supervisor shall complete an internal incident report documenting the youth's statement and all information shall be submitted to the facility administrator before the end of their shift, and the administrator on duty shall ensure all appropriate notifications are made. The program is scheduled for Trauma Responsive and Caring Environment (TRACE) self-assessment on November 4, 2019. There have been two incidents related to physical, psychological, or emotional abuse since the program began accepting youth on January 28, 2019. One incident was substantiated. The substantiated incident was related to physical abuse from an improper Protective Action Response (PAR) move. The incident was reported to the Florida Abuse Hotline and the Central Communications Center (CCC). Seven youth were interviewed. All seven reported they feel safe and none reported they have ever been stopped from reporting abuse. Four youth reported staff are respectful when talking with them and other youth, the remaining three indicated some staff can be disrespectful at times. Of the seven youth, one reported never hearing staff using profanity, two stated occasionally, and four reported often. Three reported the staff use profanity when giving directions to the youth, two reported staff curse with the youth not at them, and one

reported staff curse “playfully.” Seven staff were interviewed. All seven stated if a youth requests to make an abuse call they would notify their supervisor. Five indicated the supervisor allows the youth to make the call. All seven indicated they have never observed a co-worker tell a youth they could not call the Florida Abuse Hotline. All seven stated they have never observed a co-worker using profanity, threats, intimidation, or humiliation when interacting with youth. The program director confirmed the program’s staff code of conduct indicates staff must maintain a professional demeanor with the other staff and youth. He further confirmed the steps for the incident reporting process for the Florida Abuse Hotline and CCC.

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 program director indicated he ensures staff and youth are knowledgeable in contacting the Florida Abuse Hotline or Central Communications Center (CCC) through postings throughout the program with all pertinent information regarding contacting the abuse registry or CCC. Additionally, all incidents are tracked in the program’s incident report tracker and all calls to the abuse registry and CCC are discussed in the daily management meeting and daily shift briefing for all shifts and professional staff. There was one incident of disciplinary action due to allegations of abuse toward youth since the program began accepting youth on January 28, 2019. In this case, a Protective Action Response (PAR) move was not completed properly. In the employee record, there was evidence management took immediate action to address the incident. The staff member received a written warning as a result.

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.	

There were twenty-five incidents reported to the Central Communications Center (CCC) during the previous six months; five were reviewed. In each case, the incident was reported within two hours of the program becoming aware of the incident. Four of five 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 PAR incidents; five were reviewed. In all five, the report was completed by the end of the staff member’s workday and the report included statements from all staff involved. In one case, the youth

alleged abuse and the Florida Abuse Hotline was contacted immediately. In all five, a review was conducted either by PAR certified instructor or supervisory staff. A PAR medical review was conducted when the post-PAR interview indicated a need. Documentation also reflected the post-PAR interview was conducted with the youth by the administrator or designee no longer than thirty minutes after the incident. Documentation also confirmed the PAR incident report was reviewed by the administrator or designee, within seventy-two hours of the incident, excluding weekends and holidays in all five incidents and the PAR report was placed in the program's centralized file within forty-eight hours of being signed by the administrator.
The program's PAR rate during the annual compliance review period was 2.63, which is above the statewide Residential PAR rate of 1.59.

1.07 Pre-Service/Certification Requirements (Critical)	Failed 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 training 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 topics on January 23, 2019.The training plan was approved and signed by the Office of Staff Development and Training on February 7, 2019. Seven staff were reviewed for pre-service training. Each completed over 120 hours of training; however, only three had completed the trainings required based on the training plan to be certified within 180 days of hire. Four staff had not completed trainings which are considered essential skills which must be completed prior to any contact with youth; all four had not completed child abuse reporting which is indicated on the pre-service training plan as a one-hour course which will be completed in the Department's Learning Management System (Skillpro). Additionally, one staff had not completed ethics, or Prison Rape Elimination Act (PREA) prior to contact with youth. Two staff were hired in January 2019, one was hired in February 2019, and one was hired in March 2019. The staff member hired in January did not complete ethics, PREA, or child abuse reporting until October 5, 2019. The other staff member hired in January did not complete child abuse reporting until September 27, 2019. The staff member hired in March did not complete child abuse reporting until October 7, 2019. The staff member hired in February had not completed the child abuse reporting prior to the end of the annual compliance review. The program's contract also specifies youth care worker III's, shift supervisors, and unit managers are to complete Certified Behavioral Health Technician training within six months of hire. Three staff reviewed were eligible for this requirement. Documentation was shown to reflect each is enrolled and in the process of completing certification, but none have become certified within the timeframe specified.

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 on January 23, 2019 and the training plan was signed on February

7, 2019. 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 as the program has been open less than a year.

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 training requirements of the grievance process. Seven staff training records were reviewed and reflected all seven received training. The program's grievance process includes the following phases: informal, formal, and appeal phase. 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 filled out and submitted into a secure box. The forms are assigned to staff in daily management meetings and are to 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 working 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. Five grievances were filed in the past twelve months. Two grievances were resolved at the formal phase within two days. Two grievances were resolved at the formal phase within four days. One grievance did not have a date given. Seven youth were interviewed. All seven indicated forms are placed throughout the facility. All seven indicated they can ask for assistance in completing the form. One youth indicated he has never written a grievance and is not sure how the process works. Three youth indicated there are three phases of the process. Two youth indicated there are timeframes for each phase. One youth indicated he has never heard back regarding grievances he has filed. Seven staff were interviewed. All seven indicated forms are placed throughout the facility. Seven indicated the program director reviews grievances. Six indicated youth can ask for assistance in completing the form. Five indicated the process has three phases, each phase has associated timeframes, and grievances are reviewed by a supervisor. The program director indicated there are three phases of the grievance process. Staff shall ensure youth requesting to file a grievance be given the proper forms, assistance, and instructions on the preparation and submission of the grievance.

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

The program 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 evidenced-based practice intended to assist youth in recovering from trauma. In addition, the program utilizes Skillstreaming the Adolescent and Seeking Safety practices with demonstrated effectiveness to assist youth with prosocial skills, mental health trauma, and substance abuse related issues. Also, the program provides Young Men's Work as a gender-specific programing group to the youth. The program director confirmed staff education and work experience is 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 their 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 are being delivered as indicated on the program's schedule.

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 intervention specifically addressing communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking, including problem-solving and decision-making. A review of the program's schedule reflects life skills groups are provided and which was confirmed through group sign-in sheets. All seven youth who were interviewed reported participating in groups. Six were able to list skills they learned in group and referenced how they practiced the skills in and out of group. One stated he had not learned much from the groups he participates in.

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 they have caused by their past criminal acts, challenging them to recognize and modify their 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 as restitution activities and community service projects. Staff conducting IOC groups each had the required training as documented in their training records. The program's activity schedule and group sign-in sheets confirmed restorative justice groups are provided and occur as scheduled. Seven youth records were reviewed and four of the youth are currently participating or have previously participated in IOC. Three youth have not participated in Impact of Crime as the group is a closed group. The IOC group was unable to be reviewed during the course of the annual compliance review.

1.13 Gender-Specific Programming	Limited 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 provider's contract lists Young Men's Work and Talks My Father Never Had with Me as the required services which will be provided to address gender-specific programming. The program is currently only providing Young Men's Work to address the characteristics of the primary target population (age, gender, and service needs) and could not provide a reason for not providing Talks My Father Never Had with Me to the youth The program's activity schedule provides for gender-specific programming. Documentation reflected gender-specific programming is not being delivered according to the schedule or the requirements of the group. Young Men's Work is to be provided one to three times a week for one hour. Based on group sign-in sheets the group is not always provided for an hour. There were sixty-one groups provided since April 2019. Fourteen were only thirty minutes long. However, since September 2019 gender-specific groups were consistently conducted for one hour. Group sign-in sheets were also titled Seven Challenges/Young Men's Work making it unclear which group was actually provided. The program director confirmed the program provides Young Men's Work as the intervention which has components addressing the needs of the male population.

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

The program has a 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 their alerts were removed or downgraded by the appropriate staff. The health services administrator (HSA) addressed all medical alerts and mental health alerts such as suicide alerts were addressed by the clinical director. The program director indicated alerts are reviewed with the healthcare staff daily during the morning management meeting. During this meeting all pertinent information as it relates to the health and wellbeing of all youth throughout the program is discussed. During the weekends and hours in which medical coverage is not available, shift managers and unit managers are trained to treat youth's basic needs and all major issues are reported to the HSA and program director upon gaining knowledge of any medical issues. Seven staff were interviewed and four indicated they are informed of alerts through the programs alert board, four reported during daily shift briefings, and one indicated each youth has a document available to youth care workers listing their 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 contained the following information: youth's name, Department of Juvenile Justice Identification number, date of birth, county of residence, and committing offense. The individual management record contains the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. Youth records were labeled "Confidential." All official youth case records are secured in a locked file cabinet or 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 include avenues such as youth advisory board minutes, program surveys, and suggestion forms. Seven youth were interviewed regarding the process for youth to provide input and all seven indicated the program conducts weekly house meetings. The program director indicated youth have access to Let's Talk forms which upon completion staff meet with youth to discuss any issues or concerns. The program director also indicated the program conducts a daily meeting in which all youth and staff are present for open discussion.

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. Sign-in sheets confirmed this practice. Documentation confirmed the program director solicits active involvement from the following: law enforcement, judiciary community, community partners, business community, school district, faith community, victim, victim advocate, or other victim services community representative, and a parent/guardian whose child was previously involved in the juvenile justice system. Sign-in sheets confirmed participation from all members with the exception of law enforcement and judiciary community; however, the program continues to reach out to these community partners. The program director explained the individuals involved in the community advisory board assist in program planning of activities and speakers along with providing mentoring services to the youth. Additionally, community advisory board members relay their recommendations during the quarterly meetings. The board has successfully implemented a movie night with the youth, religion study on Fridays, religious services on Sunday, community service projects, restorative justice projects, pro-social leisure activities, and equestrian outings.

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

The program director ensures provisions for staffing including a system of communication to keep staff informed and give them opportunities to provide input and feedback pertaining to operation of the program; and staff retention planning including steps to minimize turnover and improve employee morale. The program director explained the program has recently implemented a morale committee to address the needs of the staff. The program has experienced turnover throughout the process of opening. He further explained, staff partake in prosocial activities off campus as well as staff appreciation days/weeks and special events. The program has also been successful in promoting from within which adds to increased employee morale. In addition, the program is introducing a new staff scheduling format allowing direct care workers to have at minimum one weekend day off each week. The program utilizes surveys from youth, parents/guardians, and staff which are completed monthly and quarterly; this information is used to determine program morale for both youth and staff and is 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 briefing is conducted with each shift to include the chief of security, unit managers, and the assistant facility administrator. Weekly meetings are held with shift supervisors and monthly all staff come together for a meeting. Shift meetings are also held as needed for each shift. Seven staff were interviewed, and all reported staff meetings are held monthly, four also reported meetings are held daily. Topics discussed include: policies and procedures, areas staff are doing well and areas needing improvement, program updates, youth alerts, and safety or security issues. Four staff stated the topics were informative. Six of the seven staff reported they are not briefed on youth and parent/guardian survey results. Of the seven staff interviewed four believe communication amongst staff at the program is very good, one reported good, one fair, and one poor. Concerns regarding communication included missing out on certain issues since everyone works a different shift, and communication does not make it all the way to the top from youth care workers it gets stuck in the middle between supervisors. All seven staff reported they are able to provide input and feedback into the program operations.

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 then annual reviews of all employees. A review of seven staff's position descriptions ensured each staff member's performance standards are clearly identified. Each of the seven staff had an initial ninety-day performance evaluation. One of the seven staff reviewed had performance standards which did not match his job description. The performance standards reflected unit manager; however, his job description is for youth care worker III. Additionally, this staff is acting in the position of unit manager which, based on the program's contract, requires a bachelor's degree and the staff does not have the required degree. The program was instructed the staff was not qualified to fill the position, even in an acting capacity, and instructed the individual needed to vacate the position and list it as a vacancy so it could be filled by an individual who meets the minimum requirements. An interview with the program director indicated all staff will receive an annual evaluation which depicts how the staff has performed throughout the course of the year. Upon completion of the evaluation process each

staff meets with the program director and the manager to discuss areas of improvement and to develop a plan for success. Seven staff were interviewed and all indicated they receive an initial ninety-day evaluation; three staff also indicated an annual 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 provide 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. 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 opens, 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 recreational therapist who has a degree in recreation. A review of seven youth records confirmed therapeutic activity provided is incorporated into the youth's individualized performance plan. The program also has a formal process to promote constructive input by youth through a youth advisory board which meets weekly. Seven staff were interviewed, and all reported youth receive one hour of recreation a day. They listed activities provided as board games, football, basketball, cards, and video games. Seven youth were interviewed, and all reported receiving one hour of recreation each day. The youth listed activities as cards, board games, basketball, football, and soccer.

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.	

Seven case management records were reviewed, and all indicated the program notified the parent/guardian by telephone within the twenty-four hours of admission. Six of the seven case management records indicated the program notifies parent/guardian in writing within forty-eight hours of admission. Seven case management records were reviewed, and six out of the seven records included documentation to support the committing court was notified 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.	

Seven case management records were reviewed, and all indicated the program provides each youth with a program orientation within twenty-four hours of admission. Orientations included all required elements such as services available, expectations, responsibilities, access to medical services, access to the Florida Abuse Hotline and access to mental health services. Seven youth were surveyed, and all responded they received orientation within twenty-four hours of admission into the program.

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

A review of three records for youth eighteen years or older indicated the program had documentation of consent before discussing physical or mental health screenings, assessments, and treatment with the youth's parent/guardian.

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.*	

Seven case management records were reviewed, and each record indicated the program had documentation youth are initially classified on the date of admission. The program has a system in place used for the purpose of classifying a youth's physical characteristics, maturity level, gang affiliation, of assigning youth to living area and sleeping room, suicide risk factors to include medical, mental health, substance abuse, security, and special needs. All youth identified as having risk factors were entered into the Department's Juvenile Justice Information System (JJIS). The Youth Risk Assessment binder was reviewed and there is documentation to include youth were reassessed monthly for an increase in youth's privileges or freedom of movement, participation in work projects, and or off-campus activities.

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.	

Four case management records were applicable for suspected gang involvement were reviewed. All youth entering the program are screened for gang involvement and affiliation. The local law enforcement is notified as well as the juvenile probation officer (JPO) and the home county where the youth resides. Of the four cases reviewed, the program notified law enforcement in the case management records. In each of the four cases education was notified as well as the post-residential counselors. Each had a gang alert entered in the Department's Juvenile Justice Information System (JJIS).

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.	

Four case management records were applicable for suspected gang involvement were reviewed. Each youth's individual performance plan included gang prevention goals and each youth participated in gang prevention and intervention strategies. The program provides Gang Resistance Education and Training as the intervention strategy for youth. The program maintains a gang notebook which includes gang awareness and prevention training for the 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.	

Seven case management records were reviewed for Residential Assessment for Youth (RAY) Assessment and Reassessment. Four youth records revealed the youth had a Residential Positive Achievement Change Tool (R-PACT) completed within thirty days of admission, the remaining three had a RAY completed within thirty days of admission. Of the seven case management records, the program conducted reassessments in four of the records within ninety days after completion of the initial R-PACT or RAY. The remaining three were not due for a reassessment. Initial assessment was entered in the Department's Juvenile Justice Information System (JJIS).

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

Seven case management records were reviewed. Each record contained documentation the youth had a Youth Needs Assessment Summary (YNAS) completed within thirty days of admission and was maintained in the Department's Juvenile Justice Information System (JJIS), as required.

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.*	

Seven case management records were reviewed for performance plan goals based on the findings of the initial assessment of the youth within thirty days of admission. Treatment team was present during the development of the individual performance plan. All seven records indicated criteria were met in the performance plan goals including specific delinquency intervention and measurable outcomes to decrease risk factors/increase protective factors.

There were individualized goals based upon the prioritized needs reflecting risk and protective factors identified during the initial assessment process. The performance plans also included court-ordered sanctions which could be initiated/completed while the youth were in the program. Three case management records were reviewed for transition activities and all were targeted for the last sixty days of youth's stay. The youth and program were responsible to accomplish goals and there was a target date for completion. All seven records reviewed had documentation supporting the program included the youth's noted gang involvement in 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.	

Seven case management records were reviewed with four of them resulting in revisions to youth's performance plan when determined necessary by the intervention and treatment team. These revisions were made as a result of newly acquired information regarding the youth, the youth's progress toward completing goals, or the youth's demonstrated lack of progress in completing goals. Revisions to the individualized performance plan were made to facilitate transition activities during the last sixty days of the youth's stay in all four applicable cases.

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.*	

A review of five case management records found the performance summary completed at ninety-day intervals, beginning ninety days from the signing of the youth's performance pan, or at shorter intervals when requested by the committing court. Performance summaries were completed for two youth during discharge. All 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. Transmittals were sent to the parent/guardian, committing court, and juvenile probation officer (JPO). All original summaries were found in the youth's record and were signed by all parties. Copies of the performance summary were sent to youth's JPO, committing judge, and parent/guardian within ten days of completion of the summary. All closed records showed a copy of the summary was maintained in the record and the original was sent to the JPO with the Pre-Release Notification (PRN). Seven youth were surveyed and four of the seven responded they have received a copy of their performance summary. The remaining three stated they have not received a copy of the performance summary sent to the court. However, two of the youth were not due for completion of a performance summary.

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

Seven case management records were reviewed. In all records, the parent/guardian was involved in the case management/assessment process, invited to participate in the development of the performance plan, and were given progress reviews regularly. The youth's parent/guardian was contacted, by phone, and the signature page of the performance plan was returned with the parent signature. There were letters to youth's parent/guardian informing them of formal treatment team meetings for the youth. The letters included the month and the year of the formal treatment team meeting. The program corrected the notifications while on-site to include the date and time of the formal treatment team meetings. Seven youth were interviewed; four reported they have a family member who participates in treatment team, the remaining three indicated their family member does not pick up the phone when called.

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.	

Seven case management records were reviewed, and each youth had treatment team member's signatures or phone participation. Treatment team members included a treatment team leader, the youth, an administration person, a living unit representative, treatment staff, educational staff, juvenile probation officer (JPO), and parent/guardian. There is also written input from living unit representatives as well as from education and medical staff.

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.	

Three case management records found each individualized performance plan referenced the youth's academic and treatment plan. None of the three youth records reviewed were involved with an outside agency.

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.	

Seven case management records were reviewed for formal treatment team reviews. All seven youth were applicable for formal and informal treatment team reviews. Treatment team formal reviews were completed at least every thirty days and contained the youth's name, date of review, attendees, and written comments from the treatment team, youth progress, revisions, positive and negative behaviors, and any physical interventions. Seven youth were surveyed

and each responded they get the opportunity during treatment team meeting to demonstrate skills they have learned at the program. The seven also responded the staff reviews their performance including progress on performance plan goals, positive and negative behaviors, and treatment progress. Informal reviews were conducted at least bi-weekly and included youth's name, date of review, attendees, comments from the treatment team members, youth progress, and any revisions. The reviews also included any progress made, positive and negative behaviors, any physical interventions, and any Residential Assessment for Youth reassessment results.

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

The program provides appropriate career education based on age and is appropriate for the educational abilities of the youth in the program. In three closed records reviewed, documentation included a completed employment application, sample résumé, appropriate documents essential to obtaining employment, and an appointment with Career Source Center. In all three records reviewed, documentation was available the youth's parents/guardians and juvenile probation officer (JPO) were aware of the vocational plan for the youth. The program is a Type 2 programming level, an interview with the lead teacher indicated the program offers a career course to all the youth. Interview with the facility administrator reveals the program provides youth with Servsafe, Customer Service, Microsoft Office, cardiopulmonary resuscitation (CPR), and Fork Lift Certification through E-Tech.

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.	

Marion County Public Schools provides the education on a 250-day calendar distributed over twelve months which includes twenty-five hours of instruction. The youth receive credits for the education and training received while at the program. Review of the log books and interview with the lead teacher indicate minimal disruption of class during school hours. Seven youth were asked if there are a lot of interruptions during educational instruction, six reported yes and all indicated the disruptions are from other youth in the class.

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

Three closed records were reviewed for educational transition plan. Each record had an individual education transition plan developed based on youth's post release goals beginning at admission to include all key personnel related to transition activities, and included responsibility requirements, and post release needs. Three closed records were reviewed for employability as a transition goal and included provisions for continuation of education and or employment, appropriate documents essential to obtaining employment and documentation the youth's case manager and parent/guardian are aware of the plan. All three has a valid Florida identification card and documentation indicating location and business hours of a local Career Source Center.

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

A review of five youth case management records found all youth had transition planning including transition conferences, which were held at least sixty days prior to the youth's target release date. Documentation confirmed the youth, treatment team leader, program director or designee, parent/guardian, and any other pertinent treatment team members are present during the conference. In addition, transitional planning is developed with the youth, education, program, and aftercare staff. Community Re-Entry Team (CRT) documentation was reviewed for three applicable youth. The CRT was conducted prior to the youth's release and in two cases the youth and case manager participated. In the other case the program did not receive notice of the CRT. In two cases there was evidence of an invitation to participate in the CRT.

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

A review of three closed case management records found all records contained an exit portfolio. Each portfolio contained a copy of the youth's identification card, social security card, birth certificate, transition plan, and calendar containing follow-up appointments. The portfolio also included completed sample job applications, résumé, vocational certificates, educational records, and school transcripts. Each youth record included the Electronic Educational Exit Plans (EEEPs) and/or referrals including educational recommendations. The program utilizes a form in which the youth and family signs stating they received their portfolio upon release.

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

A review of three closed case management records reflected the following individuals participated in the exit conference: intervention and treatment team leader, parent/guardian, education representative, juvenile probation officer, youth, and other pertinent parties. Exit conferences were separate from the transition and Community Re-Entry Team meetings in all three cases.

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) is the program's full-time clinical director, who is also a licensed psychologist, was recently hired on June 24, 2019. The DMHCA has a clear and active license in the State of Florida, which expires May 31, 2021, and is also a qualified mental health counselor supervisor. The DMHCA is on-site forty hours a week to ensure appropriate coordination and implementation of mental health and substance abuse services are taking place. The DMHCA is responsible for coordinating and verifying implementation of necessary and appropriate mental health and substance abuse services in the program. A copy of the DMHCA's license and position description were reviewed and were in compliance. An interview with the DMHCA indicated she oversees the delivery of clinical services consisting of individual, family, and group therapy sessions. The DMHCA is responsible for assisting and supervising clinical staff. The DMHCA also monitors all service provisions through a review of all clinical documentation related to mental health and substance abuse treatment in the form of progress notes, treatment plans and reviews, and comprehensive assessments to ensure each youth receives daily services.

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

The program has two licensed mental health professionals, one of whom is a licensed psychologist and serves as the program's designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the state of Florida, which expires May 31, 2021. The DMHCA is also a qualified mental health counselor supervisor. The DMHCA is a full-time employee and available for contact twenty-four hours a day, seven days a week. The program also employs a full-time therapist who was licensed in another state and temporarily has a provisional clinical social worker license in Florida. This therapist continues to work under the supervision of the DMHCA until she passes a Florida licensure exam. The provisional license is clear and expires July 8, 2020. The program has a contract with a psychiatrist who is on-site biweekly. The psychiatrist has a clear and active license in the state of Florida, which expires January 31, 2020 with a dual board specialty in adult psychiatry as well as child and adolescent psychiatry. There were no records of adverse emergency actions, discipline or complaints attached to the psychiatrist's license. A review of documentation from the past six

months confirmed the psychiatrist was on-site biweekly with one exception where his psychiatric advanced practitioner registered nurse (APRN) provided services to youth. The psychiatric APRN has a clear and active license in the state of Florida, which expires July 31, 2020. There is a signed collaborative practice protocol agreement in place between the psychiatrist and the psychiatric APRN dated March 24, 2018. Each youth admitted into the program receives an initial psychiatric evaluation within fourteen days of admission. The program is licensed in accordance with Chapter 397, Florida Statutes, to provide substance abuse services. This license was certified by the Department of Children and Families and expires April 1, 2020.

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

The program has four non-licensed mental health clinical staff providing mental health and substance abuse services. All four non-licensed staff hold master's-level degrees from an accredited educational institution and course work included counseling, therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, and typical behavior problems. Each of the four non-licensed mental health clinical staff's master's-level degrees were in counseling, marriage and family counseling, clinical social work and human services, and mental health counseling. All four of the non-licensed clinical staff work forty hours a week and coverage is divided to ensure a clinical staff is on-site seven days a week. The corporate mental health staff and designated mental health clinician authority (DMHCA), who is a licensed psychologist, provides weekly of on-site face-to-face supervision with the four non-licensed mental health clinical staff. The corporate MH staff provided supervision during the time of vacancy of the prior clinical director and completed training of the new clinical director, approximately four months. The corporate mental health staff is a licensed mental health counselor who is designated to oversee the mental health services to all the providers programs. This corporate mental health staff holds a clear and active license in the state of Florida which expires on March 31, 2021. A review of documentation from the past six months indicated supervision had been conducted each week with no exceptions. The weekly supervision was documented the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. Seven youth mental health records were reviewed, and each mental health substance abuse evaluation, initial treatment plan, and individual treatment plan completed by a non-licensed clinical staff was reviewed and signed by the corporate mental health staff along with the DMHCA in a few instances, all within ten calendar days as required.

One non-licensed therapist completed Assessments of Suicide Risk (ASR). The program provided false documentation of completed ASR training for this therapist signed by the program's corporate mental health staff on June 14, 2019. Two of the five ASRs listed on the training form were not completed by the non-licensed therapist. One of the ASRs was completed on May 30, 2019 by the corporate mental health staff and the other on June 28, 2019 by the current clinical director. The June 28, 2019 ASR was completed fourteen days after the training was allegedly completed on June 14, 2019, in which case only three ASRs would have been documented as completed by the non-licensed therapist prior to the June 14, 2019 sign off date. The corporate mental health staff stated she was under the impression she could

complete the ASR and have the non-licensed therapist watch and this would qualify as administration by the non-licensed therapist. Instructions on the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk Form (MHSA 022) and Administrative Rule 63N-1.0093(3)(a) clearly states the non-licensed mental health clinical staff person's training must include the administration of at least five ASRs or crisis assessments conducted on-site in the physical presence of a licensed mental health professional. The falsification was reported to the Central Communications Center as required, and the call was accepted.

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 screening. Seven youth mental health records were reviewed. All records documented a review of mental health and substance abuse information from each youth's commitment packet. All youth had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) administered on the day of admission and were entered in the Department's Juvenile Justice Information System (JJIS) on the same day. Six of seven MAYSI-2's were completed by trained staff. The program was unable to provide documentation of staff training for the remaining screening. One of seven MAYSI-2 screenings indicated a further assessment was required. All newly admitted youth are referred for a Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation, which is part of the program's practice. All newly admitted youth are also administered an Assessment of Suicide Risk (ASR) as part of the intake process as well, regardless of screening results. Documentation confirmed each youth had an ASR completed during intake. The facility administrator (FA) and clinical director were both notified before each youth was placed on standard supervision as a result of the ASR. Additional screenings completed by the program at intake include the Substance Abuse Subtle Screening Inventory (SASSI), Beck's Depression Inventory (BDI), Suicide Probability Scale (SPS), American Society of Addiction Medicine (ASAM), University of Rhode Island Change Assessment (URICA), and the Victimization and Sexually Aggressive Behavior (VSAB). An interview with the FA confirmed the intake process is a collaboration with case management and mental health. The intake process includes a review of the MAYSI-2 and other mental health and substance abuse information.

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 related to mental health and substance abuse assessments and evaluations. Seven youth mental health records were reviewed, and each youth was referred for a new mental health evaluation on the day of admission. All youth had a mental health evaluation completed by a therapist or corporate mental health staff within thirty calendar days of admission. Three of seven evaluations were completed by a non-licensed mental health clinical staff member and were signed by a licensed mental health professional within ten calendar days after the evaluation was completed. The new evaluation included the

following: demographic information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression, and recommendations. Each evaluation also included a substance abuse assessment which included the following: 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. Four youth were applicable for substance abuse and each record contained a signed consent for substance abuse services.

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 mental health records were reviewed. All youth were assigned to a treatment team upon their arrival to the program. The multidisciplinary team is comprised of the following: youth, program administration, direct care staff, education, medical staff, and mental health staff. The same members are documented on the treatment team forms. Treatment team was not available to be observed during the annual compliance review. Documentation reflects each youth received individual, group, and family counseling as prescribed by their treatment plan in five of seven cases. The other two did not receive treatment as prescribed, missing the monthly services for family therapy. All seven youth receiving mental health treatment had a valid Authority for Treatment and Evaluation (AET). Four applicable youth had a signed Youth Consent for Substance Abuse Treatment form and a Youth Consent for Release of Substance Abuse Treatment Records Form. Treatment progress notes are documented on an internal form containing all the required information similar to Department's Counseling/Therapy Progress Note form. Group therapy is limited to ten or fewer youth for mental health groups and fifteen or fewer youth for substance abuse groups as documented on the group sign-in sheets. All staff providing group are qualified to provide services. Seven staff were interviewed, and all confirmed direct care staff do not conduct mental health or substance abuse groups. An interview with the designated mental health clinician authority (DMHCA) indicated she oversees the delivery of clinical services consisting of individual, family, and group therapy sessions. Seven youth were interviewed and all indicated they participate in group and receive specialized therapies.

3.07 Treatment and Discharge Planning (Critical)	Limited 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. Seven youth mental health records were reviewed, and all had an initial treatment plan completed on the date of admission. The initial mental health and substance abuse plan is documented on an internal form similar to the Department's Initial Mental Health/Substance Abuse Treatment Plan form. The initial treatment plan was signed by the non-licensed clinical staff completing the plan and signed by the licensed mental health professional (LMHP) in three of seven applicable cases. The remaining four plans were completed by a LMHP. The initial treatment plan was signed by other members of the treatment team in all seven cases. Each initial treatment plan had documentation indicating it was mailed to the parent/guardian. None were signed by the parent/guardian. The individualized treatment plan is developed on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. The individualized treatment plans were signed by the non-licensed clinical staff completing the plan and signed by the licensed mental health professional within ten days of completion in four of seven applicable cases. The remaining three plans were completed by a LMHP. Six of seven individualized treatment plans were developed for each youth within thirty days of admission. The remaining plan was completed one day late. The program advised the plan was not completed within the required timeframe due to the youth being hospitalized, however a review of the youth's medical records confirm the youth was never admitted to the hospital during this thirty-day period. The youth was admitted on March 4, 2019, the plan was due on April 3, 2019, and he was taken to the emergency room in the late evening of April 11, 2019. There were no other hospital interventions noted in the youth's medical record prior to the April 11, 2019 date. One youth's individualized treatment plan lists Kissimmee Youth Academy as the program name and the signature page is from Department form MHSA 017, which is the Treatment Plan Review form. The program advised it will retrain therapists on how to properly document forms. While the plans were signed by all treatment team members, there is a noticeable gap between the signature page and the page before it on six of seven treatment plans reviewed. The program advised the gap is a formatting issue and they are working on creating their own internal form, as they are unable to edit the Department's form. Each plan included prescribed services for individual, group, and family counseling. The youth did not receive services as prescribed in four of seven cases. Two youth were receiving family therapy and it was not identified in their initial or individualized plans, nor were there any addendums to justify this service. The program advised there was no issues identified to warrant family therapy and exceeded the treatment plan dosage. One youth was prescribed monthly family therapy and three of three applicable sessions were not documented. Another youth was prescribed monthly family therapy and two of three applicable sessions were also not documented. Individualized therapy was prescribed four times a month for another youth and

three of twelve applicable sessions were not documented. Some errors on the weekly progress notes and treatment plans did not include the writer's initials. Treatment plan reviews are documented on the Department's Individualized Mental Health Treatment Plan Review form. Each youth had treatment plan reviews every thirty days following the development of the individualized treatment plan. There is a noticeable gap between the signature page and the page before it on the monthly treatment plan review forms for five of seven youth reviewed. Three closed youth records were reviewed for discharge plans. All three had a discharge plan documented on the Department's Mental Health/Substance Abuse Treatment Discharge Plan form. None of the youth were at risk for suicide upon release. Each discharge plan included a recommendation of follow-up services. Each discharge plan had documentation the plan was discussed with the youth, parent/guardian, and juvenile probation officer (JPO) at the transition and exit conferences. There was documentation validating a copy of the discharge plan was provided to the JPO, youth, and parent/guardian in all three records.

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 overlay services (SAOS). Each youth receives mental health services which includes individual, group, and/or family counseling five days a week at a minimum. Additionally, substance abuse and clinical activities include psychosocial skills training and supportive counseling, at a minimum, five days a week. Mental health groups provided do not exceed ten youth for each group and substance abuse treatment is limited to a fifteen youth maximum for each group. The designated mental health clinician authority (DMHCA) is a licensed psychologist who is on-site forty hours each week. 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 mental health records confirmed mental health services are being provided seven days a week. An interview with the DMHCA indicated additional interventions provided include Seven Challenges, Impact of Crime, Cognitive Behavioral Therapy, Skillstreaming the Adolescent, Young Men's Work, and Moral Reconation Therapy. The non-licensed mental health clinical staff carry caseloads of fifteen youth or less. An interview with the facility administrator confirmed group services are held for mental health, substance abuse, life skills, anger management, gang training, and individual and family counseling.

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 who is on-site weekly for two hours. The psychiatrist has a clear and active license in the State of Florida with a specialty in adult psychiatry as well as child and adolescent psychiatry. Each youth admitted into the program receives an initial psychiatric evaluation within fourteen days of admission. Seven youth mental

health records were reviewed for psychiatric services. All youth received an initial psychiatric evaluation within fourteen days of admission, regardless of their medication status. None of the youth arrived at the program on psychotropic medication. Three youth were prescribed psychotropic medication subsequent to their admission. The initial diagnostic psychiatric interview included the following: history of medical, mental health, and substance abuse, mental status examination, treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring. Page three of the Clinical Psychotropic Progress Note (CPPN) was completed for each youth. There was documentation reflecting the three youth on psychotropic medication have been seen for a medication review by the psychiatrist at a minimum of every thirty days. A review of documentation from the past six months confirmed the psychiatrist was on-site weekly with one exception where his psychiatric advanced practitioner registered nurse (APRN) provided services to youth. The psychiatric APRN has a clear and active license in the state of Florida, which expires July 31, 2020. There is a signed collaborative practice protocol agreement in place between the psychiatrist and the psychiatric APRN dated March 24, 2018. The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. An interview with the psychiatrist confirmed his role to conduct psychiatric evaluations, provide monthly medication management, be available for continuous on-call services, participate in quarterly interdisciplinary meetings, and evaluate youth referred for psychiatric services. An interview with the designated mental health clinician authority (DMHCA) confirmed ongoing consultation with the psychiatrist weekly to review each youth's behavior and any other concerns. A review of mental health records indicated the psychiatrist signs all individual treatment plans and treatment team reviews for youth who are prescribed psychotropic medication. The facility operating procedures related to psychiatric services and psychotropic medication are reviewed annually, with the latest review occurring on January 25, 2019. There are no standing orders or emergency treatment orders for psychotropic medications.

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

The program has a policy along with a written plan detailing suicide prevention procedures. The program's suicide prevention plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process. The program's suicide prevention plan is reviewed annually. The plan was reviewed and signed by the facility administrator, licensed mental health professional, and a corporate representative on January 25, 2019. Seven staff training records were reviewed for pre-service training. All staff reviewed had documentation of six hours of suicide prevention training.

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 placed three youth on suicide precautions after admission during the annual compliance review period. In all three cases, the youth had a completed assessment using Assessment of Suicide Risk (ASR) form. As a result of the ASR, the youth were placed on constant supervision. The suicide precautionary observation (PO) logs were completed correctly to include documented “safe housing areas”. Supervision was documented on the PO logs and the PO was authorized. A follow-up ASR was completed prior to the removal of the youth from constant to close supervision and then close to standard supervision in all three cases. The program used the Follow-Up ASR form in two of three cases. The program documented the remaining follow up on ASR form, which does not include all the elements in the ASR form as required. A conference was held between the facility administrator and licensed mental health professional to reduce the level of supervision. The parent/guardian and juvenile probation officer were notified of the suicide precautions in all three cases. Two ASRs were completed by a licensed mental health professional. One ASR was completed by a non-licensed staff who had not been appropriately trained. The training documentation for this staff was allegedly falsified. The ASR completed by the non-licensed staff was reviewed by a licensed mental health professional on the same day. A Department Juvenile Justice Information System (JJIS) suicide alert was initiated and removed for three youth placed on suicide precautions. The ASR was completed immediately after concerns were observed then placed on suicide precautions. The program has three suicide response kits located on each dorm and in the master control room. Each of the suicide response kits were checked for appropriate contents and found to be accurate. Seven staff were interviewed, and all staff were able to describe what to do in the event a youth expresses suicidal thoughts. The staff said they would notify mental health staff, search the youth room for sharp objects, maintain constant sight and sound and document supervision of the youth. All seven staff were able to identify the suicide response kit is kept on each dorm and the master control room.

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 had three youth who were placed on suicide precautions during the annual compliance review period. The precautionary observation (PO) logs were appropriately maintained for the duration the youth were on suicide precautions. The appropriate level of supervision and observations of the youth’s behavior were documented in real time. The

documented times did not exceed thirty-minute intervals. No warning signs were documented to have been observed. The PO logs were reviewed and signed by each shift supervisor as well as reviewed and signed by a mental health professional. The PO logs documented safe housing requirements. Two youth placed on suicide precaution were interviewed and stated staff were always with them and they never left alone for any period of time. The remaining youth had been released from the program prior to the annual compliance review period.

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 for pre-service training. All staff had documentation of six hours of suicide prevention training. The past three completed quarters were reviewed for mock suicide drills. A drill was conducted during the past three quarters on each shift. All twelve drills included the mock use of the suicide response kits, use of 9-1-1, cardiopulmonary resuscitation (CPR), and the automated external defibrillator (AED). All drills reviewed included one hundred percent of staff with direct youth contact participated in a suicide drill. An interview with the facility administrator confirmed mental health 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 written mental health crisis intervention services plan. The written mental health crisis intervention services plan includes, at a minimum, the following: notification and alert system, means of referral (including youth self-referral), communication, supervision (one-to-one, constant, and standard supervision), documentation, and review process. The written mental health crisis intervention services plan was reviewed and signed by the facility administrator and a corporate representative on January 25, 2019.

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

The program has a written mental health crisis intervention services plan, which was reviewed and signed by a corporate mental health representative and facility administrator effective January 25, 2019. The program has not completed any crisis assessments during the annual compliance review period.

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 along with a written emergency mental health and substance abuse services plan. The written emergency mental health and substance abuse services plan includes the following: immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health services or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 FS (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397 FS (Marchman Act), documentation, training, and review process. The written emergency mental health and substance abuse services plan was last reviewed and signed by a corporate mental health representative and facility administrator effective January 25, 2019.

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 Florida to serve as the designated health authority (DHA). The DHA has a specialty in internal medicine with a license which expires January 31, 2020. The program does not utilize a physician assistant or an advanced practice registered nurse. The DHA does not delegate clinical duties. The DHA is on-site weekly and is on call twenty-four hours a day, seven days per week. A review of the sign-in log for the DHA found he was on-site each week for the past six months with no exceptions. 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 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 two pro re nata (PRN) nurses. The contract requires four PRN nurses. The program stated they continue to advertise for additional PRN nurses. The HSA, one of the full-time RNs, and the two PRN RNs had clear and active licenses. One of the full-time RNs had an active license with obligations. The obligations required the RN be supervised while working. When the program was notified of the RN's status, the program changed her status to PRN to guarantee she is scheduled when she can be supervised while working by the HSA.

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.	

There are 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) when the program opened, January 25, 2019. The nursing protocols were signed by the DHA and the nursing staff on January 22, 2019. Nursing staff signed a cover page for the FOPs and nursing protocols. Since the program has been open less than a year, an annual review of the FOPs and nursing protocols was not applicable. All newly hired nursing 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. The FOP related to psychiatric services was signed by psychiatrist.

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). Three youth had an original signed AET filed in the record. Four youth had a signed AET filed in the record with the word copy legibly stamped on it. The AET is valid for as long as the youth is in the program or until the youth's eighteenth birthday. One youth turned eighteen years old since his admission to the program. The youth signed a consent for information to be released to the youth's parents/guardians on his birthday. An interview with the nurse indicated she calls the parent/guardian and tells them she is sending an AET for their signature.

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. Two youth required notification of over-the-counter medication beyond those covered by the Authority for Evaluation and Treatment (AET). One youth required vaccinations not consented for on the AET. Two written parental notifications for the vaccinations had been sent with no response. One youth with a chronic condition required notification for a change in medication. Verbal parental notifications were documented in the progress notes for each youth. Two youth required notification be sent for emergency care and two youth had notification sent due to on-site x-rays taken for injuries. Two youth required notification be sent due to being taken off-site for medical treatment. Written notification was sent regardless of telephone notifications. Telephone conversations were documented. None of the youth were in the care of the Department of Children and Families. Three youth required parental notification regarding psychotropic medication. For each, verbal consent was documented followed with written notification being sent. The written notification included the Clinical Psychotropic Progress Note (CPPN).

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 and utilizes the Immunization Tracking Record. One youth did not have the required immunizations and two parental consent forms were sent to the parent/guardian. None of the youth had a religious exemption from immunization. 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 screening. All seven records had documentation the Facility Entry Physical Health Screening Form (FEPHS) was completed on the date of admission. All seven screenings were completed by a registered nurse. Three youth had a change in physical custody since the youth's arrival. One youth had a change in physical custody twice. Each youth had a new FEPHS rescreening completed upon the youth's return to the program. All four 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 each youth received general care orientation upon admission to the program. The program's policy for healthcare education includes the topics of 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 the healthcare orientation. The list of healthcare contacts was reviewed for accuracy.

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.	

Seven youth healthcare records were reviewed for designated health authority (DHA) admission notification. Two youth were known to have a suspected chronic condition upon admission. None of the youth were identified as in-need of emergency care. For all seven youth, the DHA was notified by telephone of the youth's admission during intake. Notification to the DHA is documented on each youth's progress note 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 seven records indicated the HRH was reviewed by the designated health authority (DHA) with the checkbox on the Comprehensive Physical Assessment (CPA). All seven records documented the HRH was completed before or at the same time of 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 policy is in compliance with the Centers for Disease Control and Prevention and Occupational Safety and Health Administration. The program has a policy and procedures for Tuberculosis Screening. Seven youth healthcare records were reviewed for a CPA and Tuberculin Skin Test (TST). The program uses the Department's CPA form and a new CPA was completed within seven calendar days of admission for all seven youth. Each

CPA was completed by the designated health authority (DHA) and completed in accordance with the Florida Administrative Code. All sections of the CPA were marked. 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 the Tuberculosis Symptom Screening (Tier I) was completed on the Facility Entry Physical Health Screening (FEPHS) form. No 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) screening. All seven 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 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. None of the youth were determined to need rescreening when out of custody of the program. 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 in the youth record on the Health Education Record for all four youth. The contract states the program nursing staff is to conduct the HIV testing. The program has an agreement with the Marion County Health Department (MCHD) to conduct testing. The agreement with the MCHD requires the test results are 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. One youth record was applicable. Two additional records were requested and reviewed. Five 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 were documented with 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 and with the use of

an exam table. Sick Call Request forms were observed to be in the youth dorms. A sick call was observed with the youth's permission to ensure confidentiality is maintained. The youth was brought to the medical clinic by the nurse who is 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 any other youth. The registered nurse conducted the exam. No other program staff were present. Seven youth were interviewed regarding how quickly a youth can see a nurse once they make a Sick Call Request. Three youth stated immediately and four stated within one day. Seven staff were interviewed. All seven 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, including emergency medical services (EMS) are available twenty-four hours a day. Seven youth healthcare records were reviewed for episodic care. Six youth records were applicable. The six had a total of thirty-three 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 to off-site care if needed, education/instruction to the youth if needed, and placed on the alert list if applicable. Of the thirty-three episodic care incidents, three were not documented on the episodic care log. The program has two first aid kits located inside in each of the two dorms. There are three additional 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 reviewed 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 are 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 are attached to the AEDs. There was documentation the AEDs are checked monthly by the nursing staff. The AEDs were brand new to the program on January 22, 2019. The batteries expire March 2028 and the pads expire March 2024. A test was conducted on each AED. Mock emergency medical drills are conducted at least quarterly on each shift. Mock emergency medical drills were reviewed for the three quarters, since the program opened. Cardiopulmonary resuscitation (CPR) was demonstrated on each shift, each quarter. A list of emergency numbers is maintained and are inaccessible to youth. All staff receive training on the use of an epinephrine auto injector during pre-service training. All licensed healthcare staff maintain current CPR and AED certification. Seven youth were interviewed. All seven stated they can see a doctor if needed. Six of the seven youth stated they could see a dentist if they had tooth pain. Seven staff were interviewed. Six of the staff stated they are personally allowed to call 9-1-1 if a youth had a medical emergency. One staff stated the would notify his supervisor to notify master control to call since he does 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.	

Seven youth healthcare records were reviewed for off-site care. Two youth records were applicable for thirteen off-site care events. Parent/guardian notification was documented in all thirteen events. The Summary of Off-site Care form was utilized and filed in the youth 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.	

Seven youth healthcare records were reviewed for chronic conditions. One youth record was applicable. Two additional records were requested and reviewed. Two youth had asthma and one youth had a seizure disorder and obesity. All three youth were taking medication on an on-going basis. All three youth had a medical grade between two and five. All three youth were placed on the chronic condition list. Each youth had a periodic evaluation at least every three months. Each youth has a specialized treatment plan. Periodic evaluations are tracked on the Department's Chronic Physical Health Conditions Roster form. Each youth had periodic evaluation documentation in the youth healthcare record. The periodic evaluation is conducted prior to the renewal of prescription medication expired. The periodic evaluation is documented in the progress notes in the record. The designated health authority (DHA) follow-ups with the youth after off-site care. There were no indications of lapses in care or missed periodic evaluations. The Department's Problem List for each youth is 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.	

Seven youth healthcare records were reviewed for admission into the program with prescribed medication. One youth record was applicable. Two additional records were requested and reviewed. All three had the medication verified prior to being accepted into the program. The prescriptions were verified in each youth's progress notes and utilizing the prescription medication verification checklist. The designated health authority (DHA) was contacted to obtain the order to resume the specified medications for each youth. All medications have a current, valid order and are given pursuant to a current prescription. 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 are administered according to approved protocols. The standard Department Medication Administration Record (MAR) is used to document all medication and treatment. The MAR

clearly indicates medication start and stop dates. Staff initial each administered medication entry. There were no lapses or errors in medication administration. At a minimum, the nursing staff documents side effects weekly on the MAR. The Six Rights of Medication Administration are maintained. Refusals are clearly documented on the MAR and a separate refusal form. Medication administration was observed. Medication administration is the sole responsibility of the nurse during the administration. Nursing staff are not expected to supervise any other activities during this time. Youth are escorted to the medical clinic by direct care staff. Youth approach the nurse individually, at a window outside the clinic. There are no other youth at the window at the time. The Six Rights of Medication Administration are verified. Nursing staff observe youth to make sure medication is swallowed. There was no pre-pouring of medications. All medications are in a separate locked area designated for medication storage, inaccessible to youth. All non-controlled medications, prescribed and over-the-counter, are stored in a separate, secure, locked area inaccessible to youth. Narcotics and other controlled medications are stored behind two locks, in a separate locked box inside the locked medication cart. Medications are stored separately by type or form. Medications requiring refrigeration are stored in a secure refrigerator used for medication only. Syringes and sharps are secured in a cabinet inaccessible to youth. The medication cart is clean, organized and stock items are 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. Seven youth were interviewed. All seven youth stated, if they take medication, it is given to them by the nurse. All seven youth were able to describe the medication administration process as giving youth name and name of medications, then taking the medications from a cup with the youth's mouth being checked after. Seven staff were interviewed. All seven staff stated it is the nurse who provides medication.

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

Any medical equipment classified as sharps are securely stored and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed. All medications are identified and secured in a locked area designated for storage of medications. Different medication forms are separated. A perpetual daily running inventory of medication utilization for all sharps and over-the-counter (OTC) medications is maintained. All controlled substances have a perpetual inventory and are stored separately from other medications. Controlled medications are stored behind two locks, in a separate locked box inside the locked medication cart. Shift-to-shift inventory counts are conducted on all controlled substances and documented on the youth's Individualized Controlled Medication Inventory Record. The number of dosages remaining after each administered dosage is 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 in the delivery of medications only when licensed staff are not on-site. Random inventory counts were conducted on three sharps, three prescribed medications, and three OTC medications which revealed no discrepancies. Inventories for the past six months were observed. 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 per Occupational Safety and Health Administration (OSHA) and the Center for Disease Control (CDC) guidelines. The infection control procedures include common diseases of childhood, self-limiting episodic contagious illnesses, viral or bacterial infectious disease, tuberculosis, hepatitis, bloodborne 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 was documentation standard universal precautions are followed by all staff. There were no instances in which local county health department, CDC, or Central Communications Center (CCC) should have been notified regarding an infectious disease. 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 plan was reviewed and signed by the facility administrator when the program opened, less than a year ago. The exposure control plan included risk of assessment and methods of compliance. There were no instances involving the quarantining or hospitalization of at least ten percent of the total population of youth or staff. 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	Non-Applicable
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.

Standard 5: Safety and Security

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

The program's staff to youth ratio is one to eight during day time 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 confirm staff were actively supervising youth within ratio. Positive interactions between staff and youth were witnessed. Staff were able to accurately tell the number of youth they were supervising when asked. 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. There was close monitoring of youth behavior and changes in behavior by staff and consistent application of the behavior management system by staff. Staff account for youth under their supervision at all times. Youth were always observed accounted for and accompanied by staff. Video review reflected staff observe youth while they are in their sleeping rooms.

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) on file. There was 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. It is also posted and included in the youth handbook. A review of seven youth records confirm the program's BMS is provided to the youth during orientation. Rules governing conduct and positive and negative consequences for behaviors are in the youth handbook. The program's BMS 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 at 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 BMS also provides for a variety of rewards and incentives. Seven staff were interviewed. Four stated things can be taken away from youth as a consequence; they listed extra privileges such as staying up later, television, and canteen as items that could be taken away.

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 their implementation of the behavior management system (BMS). A sample of position descriptions was reviewed and specify required qualifications of staff whose job functions includes implementation of the program's BMS. The BMS does not include the following: increased length of stay, denial to youth of basic right or services, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement. Seven staff training records were reviewed and each had received training on the program's BMS. Seven staff were interviewed regarding how supervisors provide feedback to staff regarding the implementation of the BMS. Five indicated supervisors provide feedback daily during meetings or individually. One indicated supervisors always remind staff to stick to the BMS, and another indicate supervisors provide suggestions on how to address situations and what consequences should be used. Seven youth were interviewed. Four rated the BMS as fair, two good, and one very good. Five youth reported staff are consistent in the use of rewards, and two indicated staff show favoritism toward some youth. Six youth stated youth are never allowed to punish other youth, and one youth reported youth are. The program director indicated the program uses the Positive Performance System as its BMS. This system is an incentive-based system and allows the youth to know their status in the program daily along with being provided incentives for all achievements made daily. The system consists of five levels in which the youth must petition their peers and treatment team to advance from level to level.

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 132 cameras at the time of the annual compliance review, which are all operational. The video recordings are stored for forty-five days. Ten-minute checks were reviewed for eight days to include all shifts and each dorm. Checks were documented and observed occurring between eight and ten minutes. Ten-minute checks were documented in the actual time of the check and the staff initials were documented. There were two exceptions one evening when gaps between checks were fifteen and twelve minutes. Comparing times of observed checks with documented checks revealed minor discrepancies of one to two minutes as camera time and staff time did not perfectly synchronize. Seven staff were interviewed, and all seven 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 addresses youth census, counts, and tracking. Counts were observed being conducted. A review of logbooks revealed the program is conducting counts at the beginning of each shift, after each outdoor activity, and during emergency situations. There was one exception when recreation time was not documented. Seven staff were interviewed, all seven indicated counts are conducted every hour. They were also able to explain what happens if there is a discrepancy: a recount is conducted, and if necessary a supervisor will conduct the recount.

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 reviewed and found to be bound with numbered pages. All entries were observed made 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 person 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 the following in a central logbook maintained by master control: 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, admission and releases, and internal incidents reported to the Florida Abuse Hotline and/or the Central Communications Center. Shift reports were also 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 shift report, or staff review the shift report themselves. Oncoming staff sign and date the shift report for the previous shift to document their knowledge of its contents. The copy of the shift report is maintained on the dorm for forty-eight hours.

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 and includes 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, 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 is 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 on assigned rings. The program's method for daily tracking and reconciliation of keys is the key control log tracks issued keys to secured personal keys. There have been no incidents of missing or lost keys in the last six months. Seven staff were interviewed regarding the key control process. All seven indicated staff keys are given to master control upon entry, personal keys are securely stored, visitor personal keys are given to master control upon entry, chit is provided to visitors, daily tracking of keys through a key log, program keys are assigned to staff, youth do not have access to keys, and staff are to notify master control of missing keys. Six staff indicated there is an inventory of keys and youth are searched when there is a missing key. Two staff reported key is replaced if damaged.

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, metals, personal cell phones, unauthorized money, and non-facility issued keys. Youth are informed of consequences if found with contraband. Also, 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; however, the disposition is not always clear as it references "gave to supervisor" with no further information as to what the supervisor did with the item. There was one instance of contraband being reported to the Central Communications Center (CCC) as it was a tobacco product. The program director reported any suspicion of 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 CCC.

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 vocational instruction. Youth searches were also observed following access to tools, during which staff found a pencil fragment. 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. Seven youth were interviewed regarding searches. All seven reported searches occur after outdoor activities, when items are missing, after visitation, and after meals. Additionally, six stated searches occur when returning from off campus, and one reported after work detail. Seven staff were interviewed regarding searches and all seven reported youth searches are conducted any time there is 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.	

Invoices from an automotive shop were reviewed and reflected both vehicles received an annual safety inspection and any deficiencies were corrected. Transportation staff indicated they were aware seatbelts must be used during transports. A random check of personal vehicles and program vehicles was completed and reflected they were locked when not in use. The program has two vans which are used to transport youth. Each had documented maintenance records and the vehicles are always secured. The vehicles are each equipped with a fire extinguisher. There are approved first aid kits staff take with them when going on a transport. The vehicles also 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.

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 is used. During transports, there is one staff of the same gender of the youth transported. A random check of personal vehicles and program vehicles ensured they 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 use of a 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 staff were interviewed, and all seven reported staff are provided a cell phone to use during transports. All staff also reported 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 audit/inspection process which includes the following: the assistant facility administrator 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. A sample of weekly safety and security audit documents were reviewed and reflected they are completed every seven days. The program director was interviewed, and he confirmed the program utilizes a weekly safety and security audit tool to monitor and track safety and security deficiencies. He further stated this information is discussed in weekly shift supervisor meetings.

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

The program has a Facility Operating Procedure which addresses the issuance, inventory, and control of equipment and tools. Observations reflected tools are securely stored when they are not in use. All tools are marked for easy identification. Documentation reflected tools are inventoried prior to being issued for work and inventoried following work activities. All tools are inventoried daily such as sharp-edged, pointed tools (except on days not used). A monthly inventory of tools not having sharp edges or point 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 they are each trained on the intended and safe use of tools.

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 the supervision requirement 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.

Seven youth records were reviewed which confirmed each had a risk assessment completed which permitted them to use tools. Seven youth and seven staff were interviewed, and each reported they are allowed to use brooms, mops, and scrub brushes.

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. The policy and procedures outline staff responsible for providing approval if personal cellular phones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings. 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.

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 one time per month on each shift. Documentation reflected the program conducts practice drills and is prepared for immediate implementation or mobilization of the plans whenever an emergency or disaster situation necessitates. Documentation of drills confirmed there was at least one monthly drill on each shift covering the following topics: fire, medical, bomb threat, and hurricane. Documentation for all drills contained the type of drill, date and time, participants, brief scenario, 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. The program director stated fire drills are conducted monthly on each shift. COOP drills are conducted quarterly on each shift. Seven youth were interviewed. All reported they know what to do in the event of a fire. Four youth reported fire drills occur twice a month, one reported once a month, one reported once a week, and one reported two or three times a month. Seven staff were interviewed regarding the drills they have participated in. Two reported weather, three major disturbance, three bomb threat, one chemical spill, four escape drills, six fire, one medical emergency, and one reported they had not participated in any of the drills listed.

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 within the program of the plan for staff. The COOP was reviewed on January 2019. The plan addresses alternative housing plans approved by the North Residential Regional Director for the Department. The program's Disaster and COOP are a combined plan. Observation was made of the program's provision of equipment and supplies required for continuous operation and services during emergency or disaster situations. The program director indicated the COOP is located in the program director's office, assistant facility administrator's office, and 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 the following 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 the following information: youth's full name and Department identification number, admission date, date of birth, gender, and race, name, address, and phone number of parent/guardian; name, address, and phone number of the person with whom the youth resides and his or her relationship to the youth; persons to notify in case of an emergency (and contact information); juvenile probation officer (JPO) name, circuit, and contact information; names of committing judge, state attorney, and attorney of record with contact information for each; committing offense and judicial circuit where offense occurred; notation on whether or not the judge retains jurisdiction; victim notification contact information, if notification is required; physical description of youth to include height, weight, eyes and hair color, and any identifying marks; overall health status, including chronic illnesses, current medications and allergies; personal physician (if known); and a photograph of youth.

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. They were also stored in secure areas inaccessible to youth. Documentation indicated inventories are 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 Date 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 being used or stored. Youth were observed during daily cleaning activities which reflected staff spray the cleaner and youth use cleaning tools to wipe it. The program's preventive maintenance checklist was reviewed to ensure maintenance schedules and repairs are being conducted as outlined in Florida Administrative Code. Seven youth were interviewed, and six reported using window or toilet cleaner. All six reported staff spray the chemicals and youth clean it up. One youth reported using paint to paint room doors with staff and one youth indicated he had not used any chemicals or cleaning products at the program.

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

The program has a 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 has 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 of. 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 program director was interviewed and reported disposal of hazardous chemicals is accomplished within parameters of state, local, and federal laws. The maintenance staff is 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 staff will dispose of hazardous materials at the Ocala Baseline Recycling Center.

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

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

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

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

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

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

The program has a policy which specifically states they do not participate in 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 and schedule were conducted. Alternate visitation arrangements are available if there is a need from the parent/guardian. Youth are given the opportunity to communicate with their 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. Seven youth were interviewed, and all 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	Non-Applicable
The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.	

The program has a policy which states they do not use controlled observation; therefore, this indicator is rated as non-applicable.

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

The program has a policy which states they do not use controlled observation; therefore, this indicator is rated as non-applicable.

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

The program has a policy which states they do not use controlled observation; therefore, this indicator is rated as non-applicable.

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

The program is to maintain a safety plan for each youth in a centralized location for staff and includes the following areas, at a minimum: warning signs (identified by the youth or collateral contact, parents/guardians) and indicate a youth is escalating in their behavior; youth's baseline behaviors as gathered from collateral contacts, parents/guardian, youth's history, and evaluations if applicable; crisis recognition; jointly developed coping strategies, to include people and healthy environments as defined by the youth; intervention strategies preferred by the youth, and debriefing preferences. All plans were completed on date of admission and September 25, 2019. None of the seven plans reviewed were revised at thirty-day intervals. Six of seven plans were signed by the youth and therapist. The plans are self-report questionnaires completed by youth and do not reflect baseline behaviors, clinical information, collateral input from parent/guardian, or staff responsibilities to assist youth with de-escalation. Copies of the most recently updated Safety Plans for staff reference are in a binder in the conference room and have signature pages indicating staff reviewed them. Seven staff were interviewed and five reported the safety plans are in a binder in the breakroom, one reported they were unsure, and one stated in the unit manager and operations manager office. Five of seven staff stated the process for reviewing safety plans is to review the binder, one stated they were unsure, and one said there is a monthly review of different areas of safety plans.