STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Crestview Sex Offender Program

Gulf Coast Youth Services
(Contract Provider)
4445 Straightline Road
Crestview, Florida 32539

Review Date(s): January 7 - 10, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Tara Frazier, Office of Program Accountability, Lead Reviewer (Standard 1)
Jill Foy, Office of Program Accountability, Regional Monitor (Standard 4)
Lea Herring, Office of Program Accountability, Regional Monitor (Interviews)
Warren Garrison, Office of Program Accountability, Regional Monitor (Standard 3)
Donald Lasseter, Twin Oaks Juvenile Development, Program Director at JUST/TOVA, (Standard 5)
Ken Myers, Office of Education, Northwest Region Education Coordinator, (Standard 2)

Program Name: Crestview Sex Offender Program
Provider Name: Gulf Coast Youth Services
Location: Okaloosa County / Circuit 1
Review Date(s): January 7 - 10, 2020

MQI Program Code: 1161
Contract Number: 10288
Number of Beds: 15
Lead Reviewer Code: 166

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

Overall Rating Summary

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Crestview Sex Offender Program (CSOP) is a fifteen-bed program, for thirteen to nineteen-year-old males, located in Crestview, Florida. The program is operated by Gulf Coast Youth Services, through a contract with the Department. The program is co-located with Okaloosa Youth Academy; therefore, the program's management team is shared. The team consists of a program director, two assistant program directors, one food service manager, three dietary workers, two maintenance personnel, director of nursing, three registered nurses, seven therapists, five case managers, a transition services manager, designated mental health clinician authority, and a recreational specialist. The program has a full-time training manager who coordinates the training, develops the training plans, and makes sure staff meet the pre-service and in-service training requirements. The program provides juvenile sex offender treatment, as well as Pathways, Arise, Impact of Crime (IOC), and Boys Council groups. Education is provided by the Okaloosa County School Board. The youth attend school five days a week to earn high school credits and are given the opportunity to earn certifications through the Home Builder's Institute (HBI). The provider has an agreement with the designated health authority (DHA) and psychiatrist. The program currently has four full-time youth care worker (YCW) positions and one part-time YCW position vacant. The program only designates one housing unit. The program has a master control room with a master control operator. This staff documents all movements and events in which occur in the program. The program has ninety-seven cameras, with ninety-six operational during the annual compliance review.

Standard 1: Management Accountability

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

The Crestview Sex Offender Program (CSOP) and Okaloosa Youth Academy (OYA) are located on the same site and share all personnel. Personnel records from twenty-two staff were reviewed for initial background screenings. There have not been new volunteers or mentors in the program since the last annual compliance review. All background screenings were rated with an eligible status. Only one of the twenty-two staff had a break in service, as indicated in staff verification system (SVS). Fourteen of the twenty-two staff were direct care positions and required to take the pre-employment assessment tool. Seven of the fourteen staff passed the tool, however, either the program director or the assistant program director did give final hire approval for the seven staff who did not pass the tool with a “C” or above. All twenty-two staff were verified in the Clearinghouse employment roster. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and submitted to the Department’s Background Screening Unit (BSU) on December 20, 2019. The teachers are provided by the Okaloosa County School Board and received an annual screening through the BSU, which was completed and signed on January 18, 2019. The principal is currently working on one for this year. According to human resources, the program reviews each potential new hire by reviewing the Central Communication Center (CCC) person involvement history report, SVS, Florida Department of Law Enforcement (FDLE) automated training management system (ATMS) results, and reference checks.

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 written policy and procedures in place addressing five-year rescreening. During this annual compliance review, there were no staff eligible for a five-year background rescreening.

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

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

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

The program has written policy and procedures in place addressing an abuse-free environment. The program has the Florida Abuse Hotline and Central Communications Center (CCC) numbers posted throughout the facility. The program completed the Trauma Responsive and Caring Environment (TRACE) self-assessment in December 2019 and are waiting for those scores; however, documentation of the December 10, 2018 assessment was verified. The program's policy states all youth shall have unimpeded self-reporting access to the Florida Abuse Hotline and/or the Department's CCC. According to the policy, if the youth makes a request to a youth care worker (YCW) to make an abuse call, the YCW will contact the shift supervisor immediately. Youth over the age of eighteen can call the CCC. The shift supervisor will escort the youth to a private area for access to a phone to call the Florida Abuse Hotline/CCC, then return the youth to the designated scheduled location with no consequences. The shift supervisor will make an entry into the alleged abuse log and complete the appropriate form. If the youth changes his mind or refuses to make the call, the youth will then sign the abuse call refusal form. The program director (PD) is always notified. The program had one Florida Abuse Hotline/CCC call which was either physical, psychological, or emotional abuse in nature since the last annual compliance review. This incident was substantiated.

Four of the five interviewed youth reported they have never been stopped from reporting abuse to the Florida Abuse Hotline or the CCC. The fifth youth said the staff which the abuse call he made was against, kept threatening youth, saying he would get sixty-days of suspension. This staff no longer works at this program. Four of the five interviewed youth reported staff are respectful when speaking with them and other youth. The fifth youth stated it depends on whether youth make them angry.. Some staff will curse at you and some won't. The five youth were asked if they have ever heard staff use curse words when speaking to you or other youth and is so how often? One youth said never, while the remaining four said occasionally.

Five staff were interviewed and asked to explain the process for allowing staff and youth to call the Florida Abuse Hotline or CCC to report suspected abuse. All five staff were able to explain the process and who to notify per policy. These five staff were also asked if they have ever observed a co-worker telling a youth they could not call the Florida Abuse Hotline. All five stated no. These same five staff were asked if they ever observed a co-worker use profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth. All five said no.

An interview with the program director (PD) revealed the program's expectations regarding professionalism and work ethic/disciplinary action included any reports of physical abuse, threats of profanity toward youth will be investigated by management staff, and based upon findings, disciplinary action up to and including termination will be taken. The PD was also asked to explain the incident reporting process for the Florida Abuse Hotline/CCC. He replied any incidents listed as reportable on the CCC checklist will be reported within two hours of report of the incident. Any reports of abuse or suspected abuse will be reported to the Abuse Hotline and CCC immediately. Youth will receive phone calls to the Abuse Hotline as requested, and youth reports to the Abuse Hotline will be reported to the 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.	

The program had one Florida Abuse Hotline/Central Communications Center (CCC) call which was either physical, psychological, or emotional abuse in nature since the last annual compliance review. This incident was substantiated. The program provided evidence documenting management took immediate action to address the incident and corrective action was taken. The program director (PD) was asked how many staff had disciplinary actions due to allegations of abuse towards a youth since the last annual compliance review. He verified by answering one.

During an interview with the PD, it was revealed abuse reporting is discussed with youth at intake, is included in the student handbook, and is posted on all bulletin boards. He added staff are trained during the new hire process regarding abuse reporting, complete annual training regarding abuse reporting, and are refresher trained on abuse reporting through staff meetings.

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

The program had three incidents reported to the Central Communications Center (CCC)for Abuse Registry, Youth Injury, and Medical Transport, since the last annual compliance review. All three incidents were reported within two hours of becoming aware of the incident. None of the calls were documented in the logbook in master control. The program did not have any CCC reports the previous six months.

The program director (PD) was asked to explain the incident reporting process for the Florida Abuse Hotline/CCC. He replied any incidents listed as reportable on the CCC checklist will be reported within two hours of report of the incident. Any reports of abuse or suspected abuse will be reported to the Florida Abuse Hotline and CCC immediately. Youth will make phone calls to the Florida Abuse Hotline, as requested, and youth reports to the Florida Abuse Hotline will be 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 had a total of four Protection Action Response (PAR) incidents since the last annual compliance review. All four reports were completed by the end of the day with statements from all staff involved. One of the four involved a youth alleging abuse. The youth, himself, made the abuse call and the Central Communications Center (CCC) was notified within the two hours, as required. All four reports were reviewed by a PAR certified instructor/supervisory staff, a PAR medical review was conducted and documented, a Post-PAR interview was conducted with the youth by the administrator within thirty minutes, and a review of the PAR report was completed by the administrator within seventy-two hours of the incident, excluding weekends and holidays. A copy of all four reports was placed in the program's centralized file within forty-eight hours of being signed by the administer. The program director (PD) provided documentation of the monthly summaries of all PAR incidents submitted to the Department's regional office by the fifteenth of each month. A copy of the program's approved PAR plan by the Department was provided. The program's PAR rate during the annual compliance review period was 1.65, which is below the statewide Residential PAR rate of 2.35.

The PD was also asked to explain the program's process for monitoring PAR incidents and use of force. He replied by saying PAR incidents are documented and reported to the Department. Management conducts camera reviews of all PAR incidents. The program had an increase of four PAR incidents since the last annual compliance review. The PD was asked the reason behind the increase and what is the program doing to change it. He said the program is holding Town Hall Meetings to discuss behavior changes and goals to include aggression. The program is incorporating the therapist more to assist in talking to the youth. Finally, they are also using the youth's safety plans for assistance. The program is currently participating in the Right Interaction Pilot Project, Documentation in the Department's Learning Management System (SkillPro) is not available at this time, nor are the proper forms.

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

The Crestview Sex Offender Program (CSOP) and Okaloosa Youth Academy (OYA) are located on the same site and do share all personnel. A review of five staff records was conducted and four out of the five staff have exceeded the required 120 hours of pre-service training within 180 days of hire, giving them certification. The fifth staff completed ninety-eight hours with thirty-eight days left in his one hundred eighty days. All five staff completed the following training:

Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), first aid, professional and ethics, standards of conduct, suicide prevention/intervention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA). Per contractual agreement, all five staff received training in the following: restorative justice, gender specific, post-traumatic stress disorder, and stress management. All training was documented in the Department's Learning Management System (SkillPro), excluding Right Interactions. All instructors were qualified to deliver the training provided. A list of the program's pre-service training was submitted on October 2, 2018 to the Department's Office of Staff Development and Training, which included the course names, descriptions, objectives, and training hours for any instructor-led training based on the above topics. This program is currently participating in the Right Interaction Pilot Project; however, documentation in SkillPro is not available and Staff Development and Training have not developed the proper forms at this time.

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 Crestview Sex Offender Program (CSOP) and Okaloosa Youth Academy (OYA) are located on the same site and do share personnel. A review of five staff records was conducted. All five staff well exceeded the required minimum annual twenty-four training hours. All five completed the following training: cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), first aid, professional and ethics, standards of conduct, and suicide prevention/intervention. Two of the five staff did complete Protective Action Response (PAR), but all five completed Right Interaction. Per contractual agreement, all five staff received training in the following: restorative justice, gender-specific, post-traumatic stress disorder, and stress management. Two of the five staff hold a supervisory position, and both received over eight hours of annual training in the following: management, leadership, personal accountability, employee relations, communication skills, and fiscal training. All training was documented in the Department's Learning Management System (SkillPro), excluding Right Interaction. All instructors were qualified to deliver the training provided. A list of the program's in-service training was submitted on October 2, 2018 to the Department's Office of Staff Development and Training, which included the course names, descriptions, objectives, and training hours for any instructor-led training based on the above topics.

This program is currently participating in the Right Interaction Pilot Project; however, documentation in the SkillPro is not available at this time, nor are the proper forms. The training coordinator was asked which staff are considered to be direct care staff and are counted for in the staff to youth ratio. She replied, only youth care workers.

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

The program has written policy and procedures in place regarding the grievance process; however, the policy did not address the training requirement. However, the five pre-service and five in-service staff records reviewed all completed grievance training in the Department's Learning Management System (SkillPro). The program's grievance process includes the following phases: the informal phase, which is when the event took place. The formal phase, where the grievance is written and given to the supervisor, who has seventy-two hours of receiving it to respond. The appeal phase, administration has seventy-two hours of receiving to respond. The program maintains copies of grievances for the past twelve months but have not had any in over a year.

Five youth were asked to explain the program's grievance process. Four out five youth stated they have never filed a grievance before, and the fifth youth reported the program doesn't seem to follow the grievance phases or timeframes. The fifth youth added he does not want any help from staff when filing grievances out. All five youth said there were grievance forms placed throughout the facility and knew they could ask for assistance in completing the form. Four of the five youth knew the three phases and only three knew the timeframes.

Five staff were asked to explain the program's youth grievance process. All five staff said forms are placed through the facility for the youth and would assist to complete the form if requested. All five staff were able to explain the phases, timeframes, and staff involved per policy.

The program director (PD) was asked to explain the program's grievance process. He replied, one, youth writes/submits grievance, two, staff responds to grievance, three, escalation to supervisor if necessary, and four, escalation to the PD, if necessary.

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 Crestview Sex Offender Program (CSOP) and Okaloosa Youth Academy (OYA) are located on the same site and do share personnel. Nine staff records were reviewed; eight therapists and one case manager. All nine staff had the required level of education and work experience, per contract, necessary to deliver delinquency intervention services. According to the program's contract, Pathways, Arise, Impact of Crime (IOC), and Boys Council are services to be provided to the youth. The program utilizes the Department's Sourcebook of Delinquency Interventions. Pathways is evidenced-based, while IOC and Arise are a promising practice with demonstrated effectiveness. A review of the program's activity schedule determined the program is providing structured, planned programming or activities at least 60% of the youth's awake hours. A review

of the youth's sign-in sheets indicated all groups were delivered, as scheduled, as well as a review of staff training records indicated the appropriate training was received.

A review of five youth records was conducted. All five youth were involved in an evidence-based, promising practice, a practice with demonstrated effectiveness, and any other intervention approved by the Department. All five youth were involved in a delinquency intervention which addressed a priority need identified on the youth's Residential Assessment for Youth (RAY), and the specific need was also placed in each of the youth's performance plans.

The program director (PD) was asked to explain how a staff member's education and work experience were considered when determining which staff would deliver life skills training or groups. He said youth are assigned to specialized case managers and counselors based upon their commitment packet and program. Consideration is made when assigning youth based upon individual background. The RAY is reviewed and utilized to determine appropriate intervention groups. The PD was also asked to explain how youth are matched to staff/counselors/case managers and intervention groups. He said specialized programming. The PD received another question about what delinquency intervention model or strategy is an evidence-based, promising practice, or a practice with demonstrated effectiveness has been implemented to address the priority needs of youth. He replied youth are placed in the best groups to fit their needs.

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.	

Per contract, all youth in the program are eligible to receive life and social skills intervention services through Arise. According to the program's contract, Pathways, Arise, Impact of Crime (IOC), and Boys Council are services to be provided to the youth. A review of the youth's sign-in sheets indicated all groups were delivered, as scheduled. The Arise and Life Skills curriculum includes communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking, including problem-solving and decision making.

Five youth were asked if they participate in any groups and all five said yes. All five replied they participate in groups from Arise, anger management, IOC, treatment group, sex offender group, seven challenges, pathways, and/or individual counseling. They describe the new skills or behavior they have been taught and practiced in group, as keeping my hands to myself, focus on me and not others, personal accountability, pros and cons when thinking of consequences, to tolerate people more, and to walk away instead of responding.

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

The provider's contractual agreement indicates the Impact of Crime (IOC) curriculum is to be utilized to enhance restorative justice awareness for youth. This curriculum assists youth in

taking responsibility for their actions and teaching them about the impact their crimes have on victims, families, and communities. Each youth who participates in IOC is given the opportunity to participate in on-site community service projects, such as serving food, beautifying the program, caring for the dogs when they are on-site, and more. According to the program director, if a youth has the ability to go off campus, they have worked with beautifying churches in the past as well.

A review of five youth records indicated all five youth were receiving IOC services, as verified through the sign-in-sheets. All nine staff providing this service are eligible. A review of the program's daily schedule indicates IOC groups are held every Monday and Wednesday.

The program director (PD) was asked to explain what types of restorative justice groups/activities are provided to the youth. He replied youth regularly participate in community service activities and weekly groups. The PD was also asked how youth are exposed to victim's perspective through victim speakers. He replied guest speakers and IOC groups. The PD was then asked to explain how youth are permitted to participate in activities intended to restore victims and communities. He stated IOC and community service.

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

According to the program's contract, Boys Council and Fathers in Training (FIT) are the gender-specific services provided at the program. The program's daily schedule shows Boys Council meets every Thursday, and FIT, if applicable, every Friday. A review of weekly sign-in-sheets was conducted and verified the Boys Council was conducted.

The program director was asked what ways the program address the needs of a targeted gender group. He responded the program provides boys council and fathers in training.

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 written policy and procedures in place to determine how alerts are identified, documented, updated, and communicated to staff. The program maintains an internal alert system, consisting of security, dietary and/or food allergies, and medical alerts. All dietary and/or food allergies are posted in the kitchen with the youth's picture. All medical alerts are posted in master control, the copier room, and nurses office. All security alerts are posted in

master control. All internal alerts are updated after each intake and/or when there is a change in a youth's status. A review of the internal alerts compared to the alerts in the Department's Juvenile Justice Information System (JJIS) was conducted and found no discrepancies.

Five staff were asked how you are informed of the youth's alerts including mental health, medical, and security, etc. All staff said they receive this information through posted alerts, staff, supervisors, and/or shift debriefings.

The program director (PD) was asked what formalized procedures are in place with the healthcare staff to review the important medical issues pertaining to the youth at the program and how often do you meet. He replied, medical alerts, physical entry screening, etc. The PD was also asked to explain the internal alert process and who is responsible for entering and closing out alerts in JJIS, as well as how does management review the alerts. He stated case management notifies control and appropriate staff members of alert upon admission or as any changes are made. Appropriate department enter applicable alerts. Management reviews all alerts and ensures notifications are made.

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

The program maintains an individual healthcare record, a mental health/substance abuse record, and an individual management record for each youth in the program. The file tab on the individual management and mental health/substance abuse record contains the youth's name, Department identification number, date of birth, county of residence, and committing offense. The records also have the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. All records were marked "confidential" and stored in a locked room.

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

The program currently has a formal process in place to promote constructive input by youth. The program has a suggestion box for the youth to place their written input in, a Peer Advisory Board which meets on Fridays, or the youth may fill out a request form for a Town Hall. Documentation of the minutes was provided to be reviewed of these meetings.

Five youth were asked if the program has a process allowing youth to provide input about what happens at the program. All five said yes and said town hall meetings, talk to the program director, assistant program director, or recreation therapist, or write down and submit suggestions in the dorm.

The program director (PD) was asked what the formal process to solicit input from youth on systemic issues impacting the residential community. The PD replied the grievance process and youth request forms. These are utilized to allow youth to openly address any presenting issues or concerns. The PD was also asked how to explain how youth are able to make recommendations for resolutions to improve conditions and enhance the quality of life for staff

and youth in the program. He stated Town Hall meetings, Peer Advisory Board, request forms, open access to PD and Assistant program directors.

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 an advisory board which meets quarterly, as verified by the sign-in-sheets, agendas, and an interview with a board member. A copy of the members of the advisory board was provided and consisted of the following: a law enforcement representative, judiciary community, other community partners, business community, school board or district, faith community, a victim, and a grandfather of a previous child of the program.

A telephone interview was conducted with one of the members of the advisory board. The member confirmed the quarterly meetings and spoke highly of the youth and staff at the program. Some of the youth from the program have worked on this member's church in the past and are currently working with the program director (PD) to start the project back up.

The PD was asked to describe the community advisory board for the program, including meeting times, membership, and involvement with the program. He stated community advisory boards convene quarterly and are scheduled based upon availability of members. Members include community providers, law enforcement, education, local businesses, local faith groups, etc. Members also provide various opportunities for youth in the community. The PD was also asked to explain the function of the community advisory board. The PD further revealed the program works with the community to enhance the availability of opportunity to youth within the program. Recommendations for community involvement and employment have been utilized as identified by board members.

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

The program has written policy and procedures in place addressing effective communication and staff incentive. The program has daily shift-debriefings conducted by the assistant program director (APD) or direct care supervisor. These meetings are held to discuss any pertinent information needed to pass from the previous shift. The program also conducts a monthly Team Meeting, which involve all staff, monthly supervisors meeting, and weekly Department head meeting.

All new staff are given the opportunity to have lunch with the program director (PD). To keep staff morale high and maintain staff retention, the program has cook outs, monetary gift cards, free shirt give away, recognition of birthdays, and a Christmas party for their staff.
The program completes youth and parent/guardian written surveys. Parent/guardian surveys are completed during the initial performance plan and when the youth is released from the program. Youth complete surveys quarterly. The program maintains a record of the surveys.
The program reviews the Comprehensive Accountability Report (CAR) annually. A copy of the 2018 report was provided. The program has not yet received a copy of the 2019 report.
According to the designated mental health clinician authority (DMHCA), the program uses the CAR report to look at length of stay (LOS). If a youth is approaching the average LOS for the program, they will get with the youth and develop a behavior plan with the youth to get the

release date back on track. According to human resources (HR), the program has four full-time youth care worker (YCW) positions and one part-time YCW position vacant. HR was also asked what internal performance tracking system and outcome data are being used by the program and how this information is used for the program planning and assessment purposes. She stated the program uses the Human Resource Information System, Lawson, to track the staff. She said if the PD would ever need to check on an staff's disciplinary history, he would ask for an on-demand report of the staff's disciplinary record.

Five staff were asked how often staff meetings are held. Three staff replied daily, two said weekly, two said bi-weekly, and all five said monthly. One staff added staff do a pass down, while a second added quarterly. The same five staff were asked what topics are discuss during the meeting and are they valuable and informative. The staff replied discussion is about the necessities of the job, staff expectations, any pertinent new information, and they do believe it is useful. These five staff were asked how effective do you believe the communication is amongst the staff at this program. Two replied very good, while three said good. The same five staff were asked to explain your ability to provide input and feedback into the program operations. All five staff concur administration staff are approachable.

The PD was asked to explain any problems the program has experienced with staff turnover and staff morale. What systems are in place to address turnover and morale issues. Explain staff retention planning, including steps to minimize turnover and improve staff morale. He said incentive programs are utilized to address potential turnover and morale issues. These include: employee of the quarter, perfect attendance awards, etc. The PD was also asked to explain what outcome data is being used by the program. He replied all data is reviewed and changes are made as appropriate. The PD was asked to explain how the information in the CAR report, or any other report published annually by the Department, is shared with staff and how often. He stated all data is reviewed by management staff and information is disseminated to staff members as appropriate. Input from staff members is utilized for potential improvements. The PD was also asked what meetings are regularly held and how are staff kept informed of important development or changes within each staffing component of the program daily. He replied all staff meetings, daily shift debriefings, and logbook.

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

The program has a written policy and procedures in place ensuring a system for evaluating staff. Each staff receives an evaluation after their first initial ninety-days with the program. Once completed, policy states staff will receive annual evaluations thereafter. The designated mental health clinician authority (DMHCA) provided samples of job descriptions, along with the performance evaluations which matched the position. All key positions are maintained in the program; however, during this annual compliance review, the recreational therapist's degree does not meet the contractual requirement. This is addressed in Indicator 1.20.

Four of five interviewed staff reported they receive annual evaluations and the remaining staff stated monthly. During an interview, the program director stated all staff members receive annual evaluation from the appropriate supervising staff member. These evaluations assess areas of strength and for improvement of each staff member and allow the supervisor and staff member to set goals for the coming year.

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

The recreational therapist (RT) was hired on October 1, 2019 with a Bachelor of Science - Health, Leisure, and Exercise Science/Fitness and Conditioning. This degree does not meet the contractual requirement. Per contract, the RT must possess a Bachelor's Degree of Science in Recreation and Sports Management with a track in Recreational Therapy. As of February 6, 2020, the RT has received approval for this position.

The program has a policy and procedures in place for providing youth with a variety of recreation and leisure activities. The program's activity schedule provides for structured leisure time, board games and television time, and recreation time. A copy of the RT schedule was provided. The schedule indicates the RT interacting with the youth, taking the youth off-site to the park for basketball, monitoring youth and interacting during community activities, board games, and more. All youth are encouraged to explore interests and engage in constructive use of leisure time. A random review of the logbook confirmed the youth are receiving the activities according to the program's activity schedule. The program uses the heat index guidelines as a precautionary measure to extreme weather before taking youth outdoors. The RT did provide input on all five youths performance plans through input forms.

Five interviewed youth confirmed physical and leisure activities are provided at the program for at least one hour each day. All of the youth also reported they are provided with varying degrees of mental and physical exertion throughout the day.

Five staff were interviewed and asked what types of indoor and outdoor activities are provided to the youth. All five staff listed off a variety of different activities; basketball, flag/touch football television, cards, checkers, dominos, and chess. Three staff said outdoor activities are one hour. The other two staff did not state a timeframe.

Standard 2: Assessment and Performance Plan

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

Five youth case management records were reviewed for initial contacts to parents/guardians. All five records contained evidence the program notified the parent/guardian by telephone within twenty-four hours of admission. In each of the five youth records, the program also notified the parent/guardian in writing within forty-eight hours of the youth's admission.
Five youth case management records were reviewed to determine if initial contacts were made to the youth's committing court, upon youth's admission to the program. All five youth case management records contained evidence the youth's committing court was notified, in writing, within five working days of admission. Each the five youths' copies of the committing court notification letters were sent to the committing court, the parent/guardian, juvenile probation officer and/or aftercare provider (if applicable).

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

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

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

The program obtains the 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. Five youth case management records were reviewed, of which three case management records were applicable. The three case management records contained documentation of each youth's provision of a signature and date consenting to release of information to the 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.*	

The program utilizes a classification system, in accordance with Florida Administrative Code, promoting safety and security, including classification and reassessment, as well as effective delivery of treatment services. Five youth case management records were reviewed for classification factors. All five case management records contained a classification form, which was completed on the day of admission to the program. The form reviewed initial classification factors, including physical characteristics, youth's age and level of maturity, history of violence or aggressive behavior, any special needs, gang affiliation, criminal behaviors, medical risks, security risks, and mental health risks. Five youth case management records were reviewed and a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) was completed and entered into Juvenile Justice Information System (JJIS) prior to youth's room assessment.

The program classifies the youth to a living room or area based on the program's classification system. Five youth case management records were reviewed for classification documentation. All five youth were classified according to the classification process and placed accordingly. The program has a policy in place which describes the procedures for reassessment and reclassification of youth prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities which involve tools or instruments and might be used as potential weapons, or means of escape, or participation in any off-campus activity. Five youth case management records were reviewed. There was documentation to support reassessments based on youth's needs and risk factors.

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

The program has a written policy and procedures in place which outlines the practices for gathering information on gangs and shares this information with law enforcement. Five youth case management records were reviewed for gang identification and notification to law enforcement. All five youth case management records contained evidence of having completed a gang assessment. There were no other youth identified as having gang involvement in the program.

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

The program has a written policy and procedures which provides gang prevention and intervention strategies when youth are identified as having gang involvement. The program utilizes Impact of Crime courses, as well as life lessons from the ARISE curriculum, as forms of the prevention strategies. Five youth case management records were reviewed, and all addressed a delinquency intervention in the performance plan. A review of the youth's sign-in sheets indicated all groups were delivered, as scheduled

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

Five youth case management records were reviewed for completion of the Residential Assessment for Youth (RAY**)** within thirty days of admission. Five reviewed youth case management records indicated the RAY was completed within thirty days of each youth's admission to the program. The initial RAY was maintained in each youth's case record and located in the Department's Juvenile Justice Information System (JJIS). All five records reviewed were applicable for RAY Re-Assessments. All five re-assessments were completed within ninety days of the initial assessment.

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

The program ensures a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission. The program maintains all documentation of the YNAS. Five youth case management records were reviewed for the completion of the YNAS. All five youth case management records contained a copy of the YNAS which were completed within thirty days of admission. Each YNAS was maintained in the Department's Juvenile Justice Information System (JJIS).

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

The program maintains a written policy and procedures to ensure the intervention and treatment. The treatment team and youth develop an Individual Performance Plan (IPP) within thirty days of admission. A review of five youth case management records contained an IPP developed within thirty days of the youth's admission. Two of the five case management records indicated the Department of Children and Families (DCF) involvement. All IPPs included acknowledgement by the youth, treatment team leader, medical staff, therapist, administrator/designee, education staff, juvenile probation officer (JPO), and parent/guardian participated in the development of the IPP. The IPPs of the DCF involved youth indicates that the DCF counselor participated by phone. Each record also contained documentation indicating a copy of the IPP was sent to the committing court, assigned JPO, and parent/guardian.
All five IPPs included each youth's individualized goals based upon risk and protective factors identified during the initial assessment. All these plans included the top three criminogenic needs, as well as each youth's specific delinquency intervention skill with measurable outcomes. Only four of the five IPPs were applicable to add court-ordered sanctions which can be completed while in the program. All four IPPs included the following: transition activities targeted for the last 60 days of the youth's anticipated stay, youth's responsibilities to accomplish goals, program staff responsibilities to enable youth to complete goals, and target dates for goal completion.

Each IPP had a signature of the youth indicating he received a copy, although All five youth indicated on the survey that they did not receive a copy.

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

The program maintains a written policy and procedures to address the revision of each youth's performance plan based upon the Residential Assessments for Youth (RAY). Five reviewed youth case management records found performance plan revisions for all five records. The IPPs were updated due to completion of goals or to transition services being implemented upon moving into the transition phase

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

The program maintains a written policy and procedures to address the transmittal of performance summaries. A review of five youth case management records indicated each youth youth's performance summary was completed every ninety days or less. Summaries included reports on mental health, education, performance plan goals progress, and staff and peer interactions. There were no reports of motivation to change. The performance summaries in the five youth case management records had a section for the youth to make a comment. All the summaries contained the required signatures of the youth, treatment team leader, and program director/designee. A copy of summary was sent within ten working days to the committing court, juvenile probation officer (JPO), parent/guardian. One performance summary was sent to the Department of Children and Families. A review of five youth records were reviewed for release summaries transmittals. Two records indicated the original summaries along with justification for release, sent with the Pre-Release Notification (PRN) to the JPO or discharge summary. A review of five youth case management records verified the release summaries and PRNs were sent to committing courts, assigned JPOs, and parent/guardian. The release summaries and PRNs were sent to the committing courts and JPOs at least forty-five days prior to each youth's scheduled discharge date.

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

The program encourages and facilitates involvement of the youth's parent/guardian in the case management process. Five youth case management records were reviewed for parental involvement in case management services. Each of the records contained evidence of contacts made to the youth's parent/guardian to advise of the youth's admission to the program. All five records contained evidence of parent/guardian participation in the development of the performance plan, progress review, assessments, and transition planning. The program's case manager provides the parent/guardian a written schedule of formal team meeting dates and times for the youth. All five case youth management records contained evidence of this information being sent to the youth's parent/guardian. All youth mental health records contained the written consent form obtained by the youth before sharing information with parent/guardian.

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

The youth's assigned case manager serves as the treatment team leader. Five youth case management records were reviewed for the composition of treatment teams. Treatment team members include the youth's case manager, an administration representative, a residential living unit representative, mental health staff assigned, and educational representative, the juvenile probation officer (JPO), youth's parent/guardian, and the youth. There was input from all team members including the nurse and transition coordinator. The JPO and parent/guardian are able to participate by phone, if needed.

The treatment team members, including the youth, meet and develop the performance plan, based on the findings of the initial assessment of the youth, within thirty days of admission. Five youth case management records were reviewed. Each record contained a performance plan which had been developed within thirty days of the youth's admission to the program. The five treatment plans were signed by all members of the treatment team including the youth. The five treatment plans were initialed by the youth to indicate they received a copy. All five interviewed youth reported participating in the development of their performance plan.

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

The performance plan is developed by the treatment team, including the youth, which stipulates goals the youth shall achieve prior to release from the program. Five case management records were reviewed for performance plan goals. All five performance plans contained individualized goals based on factors for education, mental health, and vocation. One of the five youth were applicable to incorporate the case plan from Department of Children and Families (DCF), and there was no documentation of this plan.

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

The program has a written policy and procedures which addresses formal and informal treatment team meetings, ensuring case managers meet informally with the youth at least biweekly and formal treatment team meetings occur at least once every thirty days. A review of five youth case management records indicated each youth received formal treatment team reviews every thirty days. Documentation included signatures of the case manager, therapist, medical staff, education, and facility administrator/designee. The juvenile probation officer (JPO) and parent/guardian participated by phone. The treatment team documentation included progress on performance goals, positive and negative behaviors, physical interventions, and treatment progress. The juvenile justice information system (JJIS) is updated at least every ninety days and at the sixty-day transition conference.

Five youth case management records were reviewed for documentation of informal treatment team meetings. Documentation in all five records revealed informal reviews were conducted. Reviews were documented in the youth's case management record, and included: youth's name, date of the review, meeting attendees or their written input, synopsis of youth's progress, progress in performance goals, and positive and negative behaviors. Each of the five interviewed youth reported they were provided an opportunity during the meeting to demonstrate skills they have learned in the program.

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

The program offers Type 2 career educational programming. It offers a Type 3 certification even though not required. The youth are required to maintain passing grades, appropriate behavior, and actively participate in the classrooms. Each youth participates in the CORE curriculum and is given the opportunity to earn their Safe Staff certification, as well as an opportunity to learn carpentry skills. The program director indicated on the survey that the youth are offered Home Builders Institute (HBI), Carpentry, woodshop, credit recovery, opportunities for outside employment, employability skills training. All youth complete a sample job application and a resume. In school, the youth complete My Career Shines, which is an assessment to help determine job interests. In a review of three closed case management records, all three youth case management records had contact information to the Career Source Center of the youth's home county All three records had documentation indicating the youth parent/guardian and juvenile probation officer (JPO) were given a copy of the youth's vocational plan. Three closed case management records were reviewed for evidence a transition plan was developed at admission. The three closed records had a transition plan developed by the education staff at the beginning of admission. The plans addressed an academic and/or employability goal. The lead teacher discusses with the youth's local transition contact the youth's education plans and/or employability plans. This information is documented on the electronic educational exit plan (EEEP) maintained in the Department's Juvenile Justice Information System (JJIS).

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

The program operates an academic program through the Rader Group, Inc. under the supervision and direction of the Okaloosa School District on a year-round basis. The youth are required to participate in educational and vocational career instruction for 250 days during the calendar year, with a minimum of twenty-five hours of instruction weekly. Ten days are designated for teacher planning and professional development. The program's daily schedule and logbooks were reviewed which showed the youth were tardy for class on an average three to five minutes each week due to the program moving the youth late to the classroom. Two of the five youth indicated there is some school time missed.

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

A review of three closed case management records was conducted, and each contained an education transition plan developed upon the youth's arrival date. Each plan was based upon the youth's post-release goals beginning at the youth's admission to the program, as required. Documentation indicated the parent/guardian was aware of the education transition plan. Each of the three records lacked signatures from the post-release school district or certified school counselor.

All three records included provisions for continuation of education and/or employment, a completed job application, a resume, and information pertaining to the youth's Career Source Center located near the area where the youth will seek employment. All three plans lack signatures of individuals who are responsible for the re-integration and coordination of the provision of support services for each youth.

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

A review of three closed case management records confirmed the program held a transition conference at least sixty-days prior to each youth's anticipated release date for each reviewed record. The program sent written notification to all required participants including the parent/guardian, the youth's juvenile probation officer (JPO), educational staff, and other pertinent parties. Reviewed documentation reflected the program's treatment team leader, facility administrator/designee, and other treatment team members participated in each transition conference. The parent/guardian and JPO participated in the transition conference either in person or by telephone. Documentation indicated transition activities were reviewed during the transition conference, including target dates for goal completion, along with any additional goals needed upon release. There was documentation to support goals for completion of transition activities were identified during the transition conference. Reviewed documentation confirmed each youth participated in a Community Re-Entry Team (CRT) meeting prior to their release from the program.

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

The program maintains a written policy and procedures to address the development and contents of a comprehensive exit portfolio for each youth. A review of three closed case management records confirmed an exit portfolio was completed by the program and was provided to each youth to assist with a successful transition back into the community. Each record contained a copy of the youth's birth certificate, social security card, and State of Florida identification card. Each record contained a résumé, sample job applications, education records, and a calendar with dates, times, and locations of follow-up appointments within the community. Reviewed documentation confirmed a copy of the exit portfolio was sent to each youth's juvenile probation officer (JPO), and education transition contact from the youth's home county.

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

Three closed youth case management records were reviewed for exit conferences. All three records indicated the conferences were held at least fourteen days prior to the youth's release date. All conferences were documented in the case management record and included the date of the conference and signatures of participants, including the treatment team leader, education representative, youth, and treatment staff. Documentation of parent/guardian and juvenile probation officer (JPO) was also observed to be noted as participating by telephone. Transition goals are reviewed at the exit conference. The program conducts exit conferences separate from transition and Community Re-Entry Team (CRT) meetings.

Standard 3: Mental Health and Substance Abuse Services

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

The program's written policy, developed by the program's director, makes provisions for administrative oversight and management of mental health and substance abuse services. The program provides specialized sex offender treatment services. The program has a single licensed mental health professional designated as the designated mental health clinician authority (DMHCA). The DMHCA is responsible for coordination and implementation of mental health and substance abuse services. The DMHCA is a licensed under Chapter 491 and is a licensed mental health counselor. Upon review, the license expires March 31, 2021. According to sign-in sheets and the master control log book, the DMHCA is on-site weekly for forty hours or more, as required contract. Sign-in logs determined the DMHCA was on-site a sufficient amount of time to provide appropriate services and to implement mental and substance abuse services. The DMHCA reported the role of the DMHCA is to provide direct supervision of all mental health and substance abuse staff and ensure all clinical documentation is reviewed and is appropriately completed. The program utilizes the DMHCA and not a clinical coordinator for training in mental health and substance abuse 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's written policy, developed by the program director, documented all mental health and substance abuse services must be provided by individuals with appropriate qualifications. A review of the staff roster determined staffing was in accordance with the contract and the Department's Rule. The program has one other licensed clinical staff other than the designated mental health clinician authority (DMHCA). The licensed mental health professional, including substance abuse services, is licensed under Chapter 491 who is a licensed mental social worker. Upon review, the license expires March 31, 2021.

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

The program's written policy, developed by the program director, which addresses mental health and substance abuse services are provided by individuals with appropriate qualifications. A review of the staff roster determined staffing was in accordance with the contract. The Crestview Sex Offender Program (CSOP) and Okaloosa Youth Academy (OYA) are located on the same site and do share personnel. The program utilizes six non-licensed clinical staff. A review of educational and training requirements for non-licensed clinical staff determined each of the five staff had the appropriate training and education. The program is licensed under Chapter 397. The license expires October 30, 2020. Each non-licensed staff had documentation of being directly supervised by the designated mental health clinician authority (DMHCA). Each staff holds a master's degree from an accredited university or college in the field of social work. Each non-licensed mental health clinical staff had twenty hours of training and supervised experience in assessing suicide risk and because each staff provides substance abuse services, each staff had training in accordance with the Department's Rule. The DMHCA maintained a supervision log with at least one hour a week of on-site face-to-face interactions with the non-licensed clinical professionals. The purpose of the DMHCA's direct supervision is to provided oversight, as defined in Section 397.311. The direct supervision was recorded on the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. The DMHCA is also responsible for reviewing the Assessment of Suicide Risks, crisis assessments, and follow-up crisis assessments. The DMHCA must sign each assessment.

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 completes mental health and substance abuse screenings. Youth needs are identified, and referrals are completed as part of the screening process. The program utilizes the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2). A review of the facility operating procedures (FOP) determined the program has implemented a standardized admission/intake mental health and substance abuse screening process. The process includes a review of commitment packet information, reports, records Department's Juvenile Justice Information System (JJIS) alerts, administration and scoring of the MAYSI-2, staff training, and process for referral.

Five youth records were reviewed. The program reviewed the commitment packet information, reports, and JJIS alerts. Any existing mental health or substance abuse problems were documented for each of the five youth records. The MAYSI-2 was administered in JJIS on the day of admission. As each youth's MAYSI-2 scoring had indicated a need for further assessments, the program completed a referral. None of the youth were in crisis during the screening process. An Assessment of Suicide Risk (ASR) was completed for each youth within twenty-four hours, as the MAYSI-2 category "Suicide Ideation" indicated a need for further

assessment or other information obtained indicated a need. The clinical abuse screening was administered upon each of the five youth's admission in the program. The program utilized the Department's mental health, substance abuse screening form. All screenings were signed by the designated mental health clinician authority (DMHCA). None of the screenings determined an emergency exists for any of the youth reviewed. The staff documented a consultation with the DMHCA for all five youth records.

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.	

According to the program's written policy, youth at the program whom are identified by screenings in need of further evaluations must be referred for a comprehensive mental health evaluation and/or comprehensive substance abuse evaluation or updated evaluation.
Five youth records were reviewed. Each of the youth were identified at screening as in need of further evaluation. Two youth had an updated evaluation, as a comprehensive evaluation was conducted within twelve months of admission to the program. The remaining three youth had a new comprehensive evaluation completed within thirty calendar days of admission. Each of the comprehensive evaluations, rather updated or new, were reviewed by the designated mental health clinician authority (DMHCA). All three of the new evaluations had new information and the updated evaluations had additional information applicable to each area, based upon current information provided by the youth, parent/guardian, and youth's records.

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.*	

According to the program's written policy, mental health and substance abuse treatment planning is required. Treatment plans must focus 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. Treatment teams develop, review, and update treatment plans. Five youth records were reviewed. Each youth was assigned to a treatment team upon arrival. The team was comprised of the youth, programs administrations, living unit representatives, and the parent/guardian. Each of the youth were determined to need mental health treatment. Two of the five youth were determined to need both mental health treatment and substance abuse treatment. Each youth record had documentation of each youth receiving individual and group therapy. Family counseling by the licensed mental health professional was completed when the parent/guardian was available. Often, the parent/guardian was not available; however, documentation included soliciting the parent/guardian prior and during the counselling services.

The facility is licensed under Chapter 397. The license expires October 30, 2020. Each non-licensed staff had documentation of being directly supervised by the designated mental health

clinician authority (DMHCA). Therefore, each of the two youth whom were determined to need both mental health treatment and substance abuse treatment services were addressed appropriately in accordance with the youth's substance abuse treatment plan. The two youth also had a signed youth consent for substance abuse treatment form and a youth consent for release of substance abuse treatment records form. None of the youth required a court order for substance abuse evaluation and treatment. Four of the five youth receiving mental health treatment had documentation of properly executed Authority for Evaluation and Treatment (AET) form. The remaining youth was over the age of eighteen. All treatment notes, rather it be substances abuse or mental health, were documented on the Counseling/Therapy Progress Notes form (MHSA 018). Observations of group therapy determined group is limited to ten or fewer youth.

Five staff were interviewed. Four staff statements deduced mental health/substance abuse groups are conducted, as they reported participation for security purposes or escorts. The fifth staff reported groups are not held. No explanation was recorded for the one staff who reported groups are not conducted. The designated mental health clinician authority (DMHCA) reported individual/group therapy is provided weekly or more, as needed.

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

According to the program's policy, youth with mental disorders or substance abuse impairment must have an initial mental health/substance abuse treatment plan. The policy also addresses youth receiving discharge mental health/substance abuse treatment plan, including recommendations. Five youth records were reviewed. An initial treatment plan was developed on the day of each of the youth's admission. An initial treatment plan was developed on the Initial Mental Health/Substance Abuse Treatment Plan (MHSA 015) for each of youth receiving a mental health/substance abuse treatment. The Plan was completed by the non-licensed staff and reviewed and signed by the licensed staff with in ten days. Each plan was developed before the onset of treatment and for three of the five youth prescribed psychotropic medication, within seven days of the Initial Psychiatric Diagnostic Interview. Individualized treatment plans were signed by the mental health clinical staff and the appropriate treatment team members. Psychiatric services for three of the five youth including psychotropic medication and frequency of monitoring by psychiatrist was included in the initial treatment plan. Each youth had their individualized treatment plan completed on the Individualized Mental Health Treatment Plan form (MHSA 016) and the plan reviews were completed every thirty days on the Individualized Mental Health Treatment Plan Review form (MHSA 017).

Three closed youth records were reviewed in addition to five open youth records. Each of the three closed youth had received mental health/substance abuse treatment while in the program. Each of the three youth had a discharge plan documented on the Mental Health/Substance

Abuse Treatment Discharge Plan form (MHSA 011). None of the youth were released on suicide risk during the scope of the annual compliance review. The service needs of the youth were documented on the discharge plan. The mental health/substances abuse treatment discharge summary considered services such as therapy and substance abuse therapy. Documentation included the summary being provided to the juvenile probation officer (JPO), parent/guardian, and the youth. Exit staffing date and discharge plan date determine it was available for review. Exit staffing documented the discussion of the mental health treatment discharge summary with all appropriate parties prior to the youth's release date.

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 director and the designated mental health clinician authority (DMHCA) reported the program provides specialized sex offender treatment services, mental health treatment services, and substance abuse treatment services. The program's treatment services are provided in accordance with Florida Statute, Administrative Rule, and the provider's contract including substance abuse treatment services, juvenile sex offender treatment services, and mental health treatment services. Services are provided by qualified therapists who are authorized to provide therapy as specified in Section 490.012(8) F.S.

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****	

Psychiatric services at the program are provided by a psychiatrist. The psychiatrist is a licensed physician under Chapter 458. Five youth records were reviewed. Three of the five records reviewed entered the program on psychotropic medication. The remaining youth were not prescribed psychotropic medication. The initial diagnostic interview was completed within fourteen days and included all the elements specified in Rule 63N-1 for each. Each of the three youth received a psychiatric evaluation within thirty days of intake and had documentation of monthly medication reviews. The psychiatrist participated in treatment for each of the three youth. None of the youth were prescribed a new medication, discontinued a medication, or had a significant change in any medication. Each youth had consent. The psychiatrist reported he is on-site two days a month and sign-in sheets validated this occurrence, as the contract required the psychiatrist to be on-site long enough to provide services.

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

The program has a written plan delineating the suicide prevention procedures. The plan included all the appropriate procedures. The program director reported mock drills are conducted monthly for all staff.

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

Five youth records were viewed. Each of the five youth reviewed were placed on suicide precautions. Precautionary observation was maintained for each youth until an Assessment Suicide Risk (ASR). The ASR indicated precautionary observation could be discontinued. None of the youth warranted secure observation. The program director has a written policy and procedures to address serious suicide attempt or serious self-inflicted injury to include a mortality review for a completed suicide. The review includes: circumstances surrounding event, procedures, training, medical and mental health services, pleading factors, and recommendations. Each ASR was documented in real time on form MHSA 004. A review of logbooks found beginning and ending times were documented. The ASRs were completed within twenty hours by the designated mental health clinician authority (DMHCA) or by a non-licensed staff and reviewed by the DMHCA. Youth were not lowered or discontinued until the non-licensed staff conferred with the DMHCA. The program did not have any instances warranting secure observations. The parents/guardian were notified in each case. The Department's Juvenile Justice Information System (JJIS) determined alerts were appropriately entered when applicable. The Crestview Sex Offender Program (CSOP) and Okaloosa Youth Academy (OYA) are located on the same site and do share personnel. The program utilizes five non-licensed clinical staff. Each of the five non-licensed staff completed the required twenty hours of training and five supervised assessments under the direct supervision of DMHCA. Five staff reported notifying mental health if a youth expresses suicidal thoughts.

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

Five youth records were reviewed, and determined each youth was placed on suicide precautions. In each case, suicide precaution observation logs were completed. Logs were maintained in real time, warning signs were noted, and logs were reviewed and signed by mental health staff daily. Youth were not placed in a secure observation room and safe housing documentation was not required for any of the youth reviewed. Three of the five youth reviewed were selected for informal interviews. Each youth reported they were not left unsupervised while on suicide precautions.

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

Five staff training records were reviewed, along with fifty-percent of the program staff. Each staff received the required six hours annual training on suicide prevention and implementation of suicide precautions. Training included mock suicide drills. Mock suicide drills were held no less than quarterly for each shift. All drills include the required elements

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 crisis intervention plan detailing the crisis intervention procedures including the following: notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and review.

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 written policy delineates a crisis assessment is to be conducted by the licensed mental health professional, by the designated mental health clinician authority (DMHCA), or by each of the five non-licensed mental health clinical staff working under the direct supervision of the licensed staff. The program has not had any crisis assessments since the last annual compliance review. A review of the program's policy, crisis assessment tool and staff training records determined the program is adequately prepared to conduct crisis assessments.

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's written emergency care plan includes the following: immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Ch. 394 F.S. (Baker Act), transport for emergency substance abuse assessment and treatment under Ch. 397 F.S. (Marchman Act), documentation, training, and review.

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

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

Standard 4: Health Services

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

The program has a written policy and procedures to ensure the program maintains a designated health authority (DHA) with the responsibility for the healthcare pursuant to a written agreement or contract. The program's DHA is a licensed physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. The DHA's license expires on January 31, 2022. The DHA's specialty training is in Family Practice (with experience with adolescents). The DHA does not designate a physician assistant (PA) or advanced registered nurse practitioner (ARNP). According to the provider's contract, the DHA is required to be on-site weekly, for two hours. A review of the program's weekly clinic logs reflected the DHA is on-site weekly, with no evidence of instances where nine or more days passing between on-site visits, as indicated by the DHA's signature on the logs. However, there was only one instance in which the DHA signed in and out during the previous six months; therefore, the DHA's time on-site each week could not be verified. In the event of the DHA's absence, youth are sent to the North Okaloosa Medical Center for any medical needs. The DHA is available twenty-four hours a day, seven days a week for medical concerns, emergency care, and the coordination of off-site care. The DHA reported being on-site weekly and performs new comprehensive physical assessments (CPAs) on newly admitted youth, sick call every Monday, periodic evaluations, and is on call twenty-four hours a day. The DHA further reported communication with the registered nurse (RN) on duty, the program director or designee, who will then communicate with the program staff.

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

The program has written policies and procedures for all health-related procedures and protocols utilized at the program. The designated health authority (DHA) and program director signs and dates all respective treatment protocols. Nursing staff reviews, signs, and dates a cover page on which all facility operating procedures (FOPs), treatment protocols, and other procedures are listed. New policies or changes in policies made during the year are reviewed, signed, and dated by nursing staff for changes which occurs between annual compliance reviews. An annual review of all FOPs and protocols is completed by the program. All newly employed healthcare personnel receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, given by a registered nurse. A copy of the healthcare staff orientation packet was provided by the program. Approval of treatment protocols or standing procedures are written and authorized by the DHA and are not delegated to any other person. The review and development of FOPs or other protocols related to psychiatric services and psychotropic medication management is performed by the program's psychiatrist.

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

The program has a written policy and procedures to ensure the program provides informed consent to each youth admitted to the program and general parental authorization for healthcare is present and parent/guardians are notified of healthcare. Five youth individual health care records (IHRCs) were reviewed for an Authority for Evaluation and Treatment (AET). Three of five records contained an AET, each stamped “copy” in red ink. One youth was nineteen years of age and the record contained a signed consent for treatment and release of information by the youth. One youth record contained a court order for medical and mental health treatment, as this youth was in the care of the Department of Children and Families (DCF) where the parental rights had been terminated. AETs are valid until the youth’s eighteenth birthday. Copies of parental notifications were maintained behind the AET in the IHCR. According to the nurse, the registered nurse (RN) or case manager will contact the youth’s juvenile probation officer (JPO) in the event a new or current AET is needed.

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.	

Five youth individual health care records (IHCRs) were reviewed for parental consent/notification. One of five records was applicable for over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET), in which documentation reflected parental consent. None of the records reviewed were applicable for significant changes or discontinuation of prescribed medication. There were no changes observed in chronic conditions in which the parent/guardian were required to be notified. None of the five youth reviewed were applicable for off-site emergency care. Three of five youth were applicable for off-site non-emergent medical treatment in which documentation of parental notification was observed. Three of five youth applicable for psychotropic medication reflected parent/guardian consent on page three of the Clinical Psychotropic Progress Note (CPPN). All three applicable records reflected the CPPN had been mailed out for parent/guardian signature. Written notifications are sent regardless of telephone notifications. One of five youth reviewed was applicable for involvement with the Department of Children and Families (DCF) where parental rights had been terminated, in which a court order for medical treatment was observed. The program has a written policy and procedures in place to ensure immunization histories on each youth have been obtained, evaluated, updated, and if necessary immunizations administered following the written consent by the parent/guardian and a written order by the designated health authority (DHA). Documentation reflected all five youth reviewed had their immunizations verified through Florida Shots and/or school records on the day of admission. None of the youth reviewed were applicable for refusing consent or refusing consent due to religious reasons. According the registered nurse (RN), immunizations are verified on the day of admission through the youth’s school records or Florida Shots.

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

The program has a written policy and procedures ensuring all youth are screened for health-related conditions upon admission using the Facility Entry Physical Health Screening (FEPHS) form. Five youth individual health care records (IHCRs) were reviewed for completion of a FEPHS. Documentation in all five records reflected the FEPHS was completed by a registered nurse (RN) on the day of admission for each youth. Three of the five youth reviewed IHCRs reflected a change in custody since the youth's arrival, in which a new FEPHS was completed for all three youth by the RN on the date of their return. Documentation further reflected the designated health authority (DHA) reviewed the FEPHS for all five youth.

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

The program has a written policy and procedures in place to provide healthcare orientation and education to all youth admitted to the program. Five youth individual health care records (IHCRs) were reviewed for completion of orientation to healthcare services. Documentation in all five records reflected youth received healthcare services orientation upon admission to the program, as indicated by the youth signature and date of the healthcare orientation packet. The program's healthcare orientation included access to medical care, sick call, medication monitoring, what constitutes and "emergency," the right to refuse, what to do in the event of sexual assault, and the non-disciplinary role of healthcare providers.

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

The program has a written policy and procedures in place to ensure the designated health authority (DHA) is notified of all youth admitted with certain conditions. The program's practice is to notify the DHA for all new admissions to the program. Documentation in five youth individual healthcare records (IHCRs) reflected documentation of the DHA being notified by telephone for each youth. Two of the five youth reviewed were eligible for notification for a chronic condition. None of the five reviewed youth required notification for the need of emergency services. The DHA notification was documented in the chronological progress notes for each youth.

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

Five youth individual health care records (IHCRs) were reviewed for completion of a Health-Related History (HRH). Five youth IHCRs contained a HRH which was completed on the day of admission by the registered nurse (RN). Documentation further reflected each HRH was subsequently reviewed by the designated health authority (DHA). According the nurse, a new

HRH is completed by the nurse on duty within two hours of the youth's admission to the program.

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

The program has a written policy and procedures to ensure each youth admitted to the program will receive a Comprehensive Physical Assessment (CPA) no later than seven calendar days of admission to the program. The program uses the Department's CPA form. Five youth individual healthcare records (IHCRs) were reviewed for completion of a CPA. Five reviewed IHCRs reflected a new CPA was completed by the designated health authority (DHA) within seven calendar days of admission to the program. Three of five youth entered the program as a medical grade five and two entered as a medical grade one. Each CPA was completed in accordance with the Health Service Manual requirements. All sections of the CPA were marked with an "O" or an "X". Those sections marked with an "X" reflected comments by the DHA in the comments section of the form. All five youth refused the Tanner Stage portion of the examination in which "refused," and the youth's signature were observed on the CPA. The problem list was observed to be updated for all five youth. The program has a written policy and procedures to ensure all youth receive an evaluation of tuberculosis status and risk upon admission to the program. The written policy and procedures were observed to be in compliance with the Centers for Disease Control and Prevention new 2006 recommendation and Occupational Safety and Health standards. Five IHCRs reflected each youth had a verified tuberculin skin test (TST) completed in the last year. All five records indicated each youth received Tier I B screening was completed on the day of admission to the program. Each youth was assessed prior to being placed in the general population. The results of the TST were observed to be documented on the CPA and Infectious Communicable Disease (ICD) forms in all five records reviewed. According to the nurse, a new CPA is completed by the DHA for each youth. Additionally, the nurse reported the nurse on duty will verify the youth's TB status upon admission and if necessary, a repeat TB test is ordered.

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

The program has a written policy and procedures in place ensuring all youth entering the program are evaluated and treated (if necessary) for sexually transmitted infections (STIs). Five youth individual healthcare records (IHCRs) were reviewed for STI screening. Documentation reflected all five youth were screened for STIs. All five youth were subsequently referred for STI testing. Testing, screening, results, clinical evaluation, and diagnosis were found to be documented on the Infectious and Communicable Disease (ICD) form. None of the five youth reviewed were out of the Department's custody where a re-screen would be required. Referrals for testing for each youth were documented on the STI screening form. Observation of testing for five youth was documented in the youth's progress notes. The program has a written policy and procedures which specify a system is in place to address human immunodeficiency virus (HIV) issues. Five reviewed IHCRs reflected the youth were offered testing, counseling, and treatment upon admission to the program. Two of five youth consented to HIV testing and three refused testing. Test results were observed filed in a confidential manner consistent with F.S. 381.004. A certified HIV counselor conducted the testing and a youth's HIV status is never

included on with the internal alerts. HIV testing is completed by the Okaloosa AIDS Support and Information Services (OASIS). Pre-test and post-test counseling were observed to be documented in the two applicable youth's Health Education Record within their IHCR. A copy of the provider's 500/501 certification was available for review. Five interviewed youth reported they could ask for HIV testing.

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.	

Five youth individual healthcare records (IHCRs) were reviewed for sick call. Two of five youth IHCRs were applicable for sick call, the program provided an additional record for review. None of the three applicable youth reflected similar sick call complaints three or more times within a two week period. None of the three youth present with complaints in which medical staff were unfamiliar with. All three youth completed sick call request forms which were placed in a locked box and then provided to the nurse. Completed sick call request forms were observed to be filed with the corresponding progress note for each youth, in reverse chronological order. All three sick calls were completed by the registered nurse (RN). None of the youth were applicable for restricted housing. Observation of sick calls were documented on the youth's sick call index in the IHCR as well as the Sick Call Referral log. In the event a sick call is placed when the nurse is not on-site, staff will contact the director of nursing (DON) or designated health authority (DHA) to determine the appropriate course of action. Sick call is conducted seven days a week at 2:00 p.m. Sick call hours and sick call forms were observed to be posted and available to youth. Sick call is conducted by the RN, or the DHA if on-site during the designated sick call time. No sick calls were placed during the week of the annual compliance review; therefore, sick call was unable to be observed. Five staff members were interviewed in regard to sick call. Five staff reported the nurse responds to sick call, two reported staff, four reported the supervisor responds to sick call. One staff member added staff and supervisors escort youth to medical for sick call response. Three of five interviewed youth reported they are seen for sick call within one day and two reported they have never placed a 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 written policy and procedures in place to ensure the program maintains written healthcare procedures and practice for on-site episodic care. Five youth individual healthcare records (IHCRs) were reviewed for episodic care. Three of the five IHCRs reviewed were applicable for episodic care. Documentation reflected two of the three youth were given over-the-counter (OTC) medications. Two of the three applicable youth were placed on the call out to see the nurse for follow up. None of the three applicable youth reviewed were referred for off-site care. Progress notes contained all required elements, referral needed, parental notification, and plans for follow up/future care observed. On-site care was provided by the registered nurse (RN) and subjective, objective, assessment, and place (SOAP) format was observed. The episodic care log documents all instances of first aid/emergency care. Logs for the previous six months correspond with all on-site/off-site events observed in youth IHCRs.

Emergency medical and dental care including EMS services are available twenty-four hours a day. The program has eight first aid kits in which two are assigned to the transport vans, two are stored in master control, two in the vocational building, one in the nurse's station, and one in the kitchen. The first aid kits are fully stocked with designated health authority (DHA) approved contents. The first aid kits are monitored monthly by nursing staff to ensure they are secured and to ensure inventory. The program has one suicide response kit which is located in master control. The suicide response kit was observed to contain a knife-for-life, needle nose pliers, and a set of wire cutters. The program has one automated external defibrillator (AED) which is located in master control. Instructions are located inside the AED. Nursing staff inspects the AED once a month. AED inspections for the previous six months were available for review. The registered nurse (RN) performed a self-test of the AED during the annual compliance review in which the AED was found to be in working order. The AED pads were last changed on May 31, 2019 and the current pads expire in September 2021. The AED batteries were last changed in February 2019 and the current batteries expire in May 2024. A review of drill documentation reflected the program has conducted drills quarterly and on each shift since the last annual compliance review. Documentation further reflected mock drills included the demonstration of CPR/AED annually. If staff are identified to have not participated in a mock drill, the nurse will review the drills with them. The program has a list of emergency numbers, including Poison Control Information Center which are inaccessible to youth. The program has an approved list of supervisory-level non-licensed healthcare staff who are able to assist youth with medication administration or use of an epinephrine auto-injector. A review of training records for these staff indicated they have completed the required training. Five interviewed staff reported they are personally allowed to call 9-1-1 if a youth has a medical emergency. Five interviewed youth reported they can see a doctor and dentist if needed.

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

Five youth individual healthcare records (IHCRs) were reviewed for off-site care. Three of five youth IHCRs were applicable for non-emergent off-site care. Parental notification was observed in the three applicable IHCRs. The Summary of Off-Site Care form was observed in all three IHCRs. Documentation reflected the designated health authority (DHA) initialed all three forms. Three youth required follow-up in which the appointments were tracked using an appointment book and calendar.

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

The program has a written policy and procedures to ensure the program is proactive in providing care for chronically ill youth. Five youth individual healthcare records (IHCRs) were reviewed for chronic conditions. Three of the five interviewed youth IHCRs were applicable for a chronic condition. One of three youth was identified with a chronic condition on the Facility Entry Physical Health Screening (FEPHS) form. None of the three youth reviewed had a communicable disease. Two of three youth were taking prescribed medication on an ongoing basis. Two of the youth entered the program as a medical grade five and one entered as a medical grade one. All three youth were observed to be identified as having a chronic illness on

the program's internal alert roster. None of the youth reviewed were taking ant-tuberculosis medication. Periodic evaluations are tracked by the registered nurse (RN) using the chronic roster which indicates the dates in which the youth needs to be evaluated. Periodic evaluation documentation was observed in each youth's IHRC. Evaluations are conducted prior to the renewal of a prescription medication about to expire. Treatment orders were observed to be written clearly distinguishable for clinical staff. None of the periodic evaluations were conducted off-site. There was no indication of any missed or lapsed periodic evaluations in the documentation observed. The problem list for each youth was updated in accordance with the Health Service Rule 63-M. According to the designated health authority (DHA), periodic evaluations for youth with chronic conditions are conducted every ninety days. The DHA added, the nurse tracks the evaluations by using the chronic roster and places the appropriate treatment plan in the DHA's file for review. According to the RN, the chronic roster is reviewed weekly to schedule youth to be seen by the DHA.

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

The program has a written policy and procedures to document the program maintains a system of medication administration which ensures all medications are administered safely and effectively as ordered by the physician. Five youth individual healthcare records (IHCRs) were reviewed for medication administration. Three of five reviewed IHCRs reflected the youth entered the program on prescribed medication. Prescription verification for all three youth was observed in the chronological progress note in the record. Documentation further reflected the registered nurse (RN) contacted the designated health authority (DHA) and psychiatrist to resume the medications. All medications were observed to have a current, valid order and are given pursuant to a current prescription. Practitioner Order Forms were also observed for all three youth for continuation of their prescribed medication. None of the youth reviewed were applicable for restrictive housing. One of the three youth reviewed were applicable for over-the-counter (OTC) medication not listed on the Authority for Evaluation and Treatment (AET) in which medication was administered according to approved protocols. The Medication Administration Record (MAR) utilized by the program is pre-printed by the pharmacy (PharMerica). Staff initialed each administered medication. There were no undocumented explanations for lapses or errors in medication administration. Nursing staff document weekly side effect monitoring on the MAR. The Six Rights of Medication Administration are maintained by both licensed and non-licensed staff. There were no refusals observed for the three applicable youth reviewed. The Facility Entry Physical Health Screening (FEPHS) indicted all three youth were taking prescribed medication upon admission to the program. Appropriate notifications to the parent/guardians were made for all three youth. All medications were observed to be in a separate, secure areas 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. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stock items are stored separate from specific youth medications. Expired medication is destroyed once a month with Rx Destroyer in the presence of the pharmacist and two nurses. Medication pass was able to be observed during the annual compliance review with no issues noted. Five interviewed youth reported the nurse give outs medication and two youth added the doctor gives out medication.

Five staff reported the nurse provides the medication and two added the supervisors provides medication when the nurse is not available.

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

The program has a written policy and procedures in place to ensure all medications will be stored in a safe and secure manner consistent with State and Federal Law and the highest standards of professional practice. Medical equipment classified as sharps were observed securely stored and inventoried by using a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Medications such as injectables, topicals, drops, and liquids were observed to be separated. Observations of all controlled substances were maintained behind two locks, stored separately from other medications, and had a perpetual inventory. The program has a process in place for disposal or destruction of expired and discontinued medications. A perpetual inventory of all sharps and stock over-the-counter (OTC) medications was observed. Pursuant to the Board of Pharmacy regulatory requirements, a shift-to-shift inventory count of all controlled substances was observed to be documented on the youth's individualized Controlled Medication Inventory Record. A shift to shift count of controlled medications was observed. The program maintains an approved list of supervisory level, non-health care staff trained in the delivery of medication self-administration in the event nursing staff is not on-site. Training was observed to be completed for each staff member on the approved list. The reviewer observed the nurse inventory, two youth medications being a narcotic/controlled medication, three OTC medications, and three sharps all of which matched the perpetual inventory. Perpetual inventories of medications and sharps for the previous six months were available for review. The nurse was able to explain procedures for inventory discrepancies as well as secure storage and routine inventories of medication, disposal of medication, and the practice for securing controlled substances.

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's infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, as per Occupational Safety and Health Administration (OSHA) federal regulation and the Center for Disease Control (CDC) guidelines. The program's infection control procedures includes common, infection diseases of childhood, self-limiting, episodic contagious illness, viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV, pediculosis and/or scabies, methithicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. Additionally, the hepatitis B immunization is available to staff. There were no instances in which the local health department, CDC, or the Central Communications Center (CCC) should have been notified. The program has a comprehensive process for needle stick post-exposure evaluation. The program or designee will maintain a

separate file containing all documents for youth and staff who have experienced facility exposure, as necessary. The program's exposure control plan was found to be written in accordance with OSHA standards. The plan is available to all staff. The plan is reviewed and signed annually by the program director. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. The program director reported the exposure control plan is located in master control and is reviewed with staff annually.

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

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

Standard 5: Safety and Security

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

Observation of staff during daily activities such as school, recreation, meals, breaks, and line movements concluded staff actively supervised youth. Fourteen youth were observed being supervised by four staff during each day of the annual compliance review. Each staff was able to immediately give the correct youth counts when interviewed. Staff explained what the procedure was when they could not reconcile the count. Staff reported a recount immediately to master control and an emergency head count is conducted. In the event of a youth being missing, the program would complete a search of the program. Ratio requirements are one to eight during day time and one to twelve during night time, pursuant of the contract. A review of the program's written policy and procedures was conducted to determine the program considers active supervision as maintaining sight and sound of each youth during awake hours.

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

The program's written behavior management system (BMS) was reviewed. The BMS is clearly written and is contained in the youth's handbook. Case management provided the signed documents by the youth indicating they received a copy of the student handbook at intake. Rules governing conduct and positive and negative consequences for behaviors are posted and are in the youths' handbook. There were no changes in the program's BMS since the last annual compliance review period. The BMS was posted behind glass and was visible to all. Five staff were interviewed and all five understood the BMS. Five youth were interviewed and all five understood the BMS. The program's written BMS included provisions to maintain order and security, promote and protect youth rights, positive and negative consequences, constructive disciplinary actions which are non-punitive, opportunities for a positive reinforcement, recognition of accomplishments and positive behavior at a four to one ratio, promotes socially acceptable means for youth to meet their needs, a process for explaining to the youth the reason for any sanction imposed, an opportunity to explain his behavior, an opportunity for staff and youth to discuss impact of behaviors on others. Youth and staff discuss alternate behavior through referring to the treatment plan and identifying coping skills. The BMS promotes positive dialogue and peaceful conflict resolution. Separation of youth from population is minimal and rare. Coordination of individual behavior plans are completed. There is consistent implementation and treatment through oversight. The program director described the BMS system as a token system which provides reinforcement for behaviors and aid youth in behavioral changes.

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

The program's written policy and procedures were reviewed to ensure there is a protocol where staff are provided feedback regarding their implementation of the behavior management system (BMS). The youth care worker job description outlines specific qualifications of staff whose job function includes implementation of the program's BMS. The provider contract was reviewed and all required parties were involved in the development, implementation, and on-going maintenance of the applicable behavior management. Five staff were interviewed and stated they are reviewed on their implementation of the BMS during the annual evaluation process. The program director stated the youth care workers tally points on the point card for any points and the assistant facility director ensures the cards are correctly tabulated. Five staff were interviewed and all five indicated supervisors monitor staff use of the BMS and provide feedback through reviews and staff incentives.

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.	

A total of four direct care staff were observed conducting ten-minute checks in a manner to ensure the safety and security of each youth. Ten-minute checks were documented manually in real time. A review of video footage from December 8 and 20, 2019, January 3 and 4, 2020, and January 6, 2020 determined compliance. Ten-minute check sheets were reviewed and times documented matched the video. Each staff printed and signed their name on the room sheet and documented checks in real time after completing a ten-minute check. Five interviewed staff reported room checks are conducted every ten minutes.

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 written policy and procedures addressing youth census, count(s), and tracking. A review of the logbook determined the program documents headcounts, youth movement, and daily census. Observations of counts being conducted was observed during a shift change and outdoor activities. Five staff where interviewed on how and when youth counts are conducted and what happens when a discrepancy occurs, including emergency counts. Each staff reported counts are conducted after transition, meals, outings, and recreation. If there is a discrepancy, the program does a recount and notifies the shift supervisor, program director, and Central Communications Center (CCC).

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.	

A review of logbooks which were dated from July 2019 to January 2020 was conducted. Each logbook was bound with numbered pages. Each logbook entry was legible and included the date and time of the event, the names of staff and youth involved, a brief description of the event, the name and signature of the person making the entry, and the date and time of the entry. No logbook entries were obliterated or removed; errors were struck through with a single line and initialed by the person correcting the error. The program summarizes in a shift report the events, incidents, and activities documented in the program's logbook. A program supervisor verbally briefs incoming staff regarding the contents of the shift report or incoming staff review the shift report. Each incoming staff signs and dates the shift report from the previous shift to document they reviewed or has been verbally briefed about its contents. Copies of the shift reports are maintained in administration for approximately three years.

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*	

A review of the program's written policy and procedures on key control was completed. Observations of the distribution and collection of keys conducted by master control determined compliance with program policy. An interview with staff determined the process for restricting usage of keys such as medical, youth and staff records, and youth property locker keys is compliant with the program's policy. A review of the key inventory determined key rings on the inventory matched the actual key rings in use. The key storage area was locked and inaccessible to youth. Interviews with five staff determined there is obvious knowledge of the program's policy and procedures for addressing missing or lost keys and the reporting and replacement of damaged keys. A random check of six staff for personal keys to include two administrative staff, determined compliance. Five staff were able to explain the program's key control process including how keys are assigned, the process for missing or lost keys, damaged keys, and restricted keys. All staff reported their personal keys are placed in the designated key box. Each time staff are issued keys, their name is documented in the key log and logbook. If keys are missing, the facility is locked down, searches are conducted, the Central Communications Center (CCC) is contacted, and an incident report is completed.

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 developed and implemented a system to prevent the introduction of contraband into the program. The written policy and procedures align with the Department's recommended guidelines for contraband. The program's policy and procedures include exemptions to services provided. The program provides youth with the list of contraband items

and materials and informs the youth of the consequences if found with contraband. Staff maintains the safety and security of the program by performing searches when youth are brought into the program, searches of the facility, grounds, and incoming mail. The prohibited list of items includes personal cell phones, equipment, electronic devices capable of taking pictures and/or audio/video. The program director (PD) stated daily searches are conducted, contraband is discarded, and law enforcement is notified if necessary, as well as the Central Communication Center (CCC) if reportable, when handling the discovery of illegal contraband and its' disposal.

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.	

Observations made during the annual compliance review determined searches were conducted as prescribed by Florida Administrative Code. Searches were documented before and after visitation. Fourteen youth were observed being searched daily during movements. Searches are conducted through the youth's clothing by staff who is of the same gender as the youth being searched. Electronic search equipment may be used to supplement a full body visual search. Four staff conducted the searches each day and after each movement. Appropriate ratios were maintained. Each search was conducted appropriately based on the Protective Action Response (PAR) training manual. Five staff and five youth were interviewed on when and how are youth searches conducted. Each staff and youth reported after each transition, meals, bathroom, and recreation. Staff verbally inform the youth a search is being conducted, instructions of the search is verbalized, and the same gender as the youth conducts all searches.

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

The program utilizes two vehicles to transport youth. Both are ten passenger vans ID as #12 and #59. Van # 12 had its annual safety inspection completed on August 13, 2019 and van #59 was completed on September 4,2019. Each vehicle used to transport youth was equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and an approved first aid kit. Van # 59 had two broken door latches, graffiti were noted on an inspection completed on December 6, 2019, and a repair request was completed to repair door latches. The graffiti on seats was trying to be removed during inspection.

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.	

Observations during the annual compliance review revealed a minimum ratio of one staff for every five youth during transportation. Transporters are provided with a cellular phone. Staff were not observed transporting youth in any personal vehicles. Secure transportation is provided for all youth. A minimum of two staff, with one being the same gender as the youth, were observed during transports. Doors to the youth passenger area cannot be opened from the inside. The need for mechanical restraints were not utilized. Two vehicles used to transport youth had rear doors. Each rear door was inaccessible from the inside. A staff person occupied the passengers' compartment. Youth and staff were observed wearing seat belts during transportation and youth were not attached to any part of the vehicle by any means other than the proper use of a seat belt. Staff were not observed leaving youth unsupervised in a vehicle. Youth were not observed driving the program's or staff vehicles. Each day of the annual compliance review, staff locked all personal and program vehicles when not in use. Five staff were interviewed on what type of communication devices are provided during transports. Each staff reported a cell phone and a two-way radio.

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 written policy and procedures which outlines the weekly safety and security audits process. The program director (PD) or the assistant program director is responsible for conducting the weekly audits and safety inspections. The PD is responsible for the development and implementation of corrective actions warranted as a result of safety and security deficiencies found during any internal or external review, audit, and or inspection. There are internal systems to verify the deficiencies are corrected and existing systems are improved. The policy and procedures meet all the requirements of Florida Administrative Code. A sample of weekly safety and security audit documents were reviewed and confirmed they were completed every seven days, as required. The PD was interviewed and asked the program's process to address, identify, and track deficiencies and he responded he disseminates all perinate information to staff.

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

Tools are maintained in a locked maintenance office and a locked tool locker in vocations. Tools were marked and identified by tracing the tool on wooden board and hanging them from a nail. Each tool could be easily identified by the outlining and identification made on the board. The program provided daily and monthly tool inventory logs dating back to July 1, 2019. Comparisons of the monthly inventory of tools and the daily inventory of tools with a high potential to be used as a weapon against the actual tools at the program determined there were no tools missing from the program nor any tools at the program not listed on the inventory. Five interviewed youth reported they do use approved tools. Five interviewed staff reported youth only use approved tools, mops, brooms, and scrub brushes, however, youth who qualify for Home Builder's Institute (HBI) may use additional approved 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 written policy and procedures addressing youth tool handling and supervision and monitored by the director for compliance. The procedures ensure youth handling tools are safe and supervised appropriately to prevent injuries to the youth, other youth, and staff. Staff interviews determined tools are permitted to be utilized by the youth were approved and youth must be approved through a risk assessment to use them. Five staff were interviewed on which tools youth are allowed to use. Each staff reported mops, brooms, and approved vocation tools. Five interviewed youth reported only using mops, brooms, rakes, and approved vocation tools.

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

The program has a written policy and procedures to address when an outside repairman or worker enters the program to perform a work project requiring the use of tools. The program restricts tools to those necessary, checks tools upon the worker's arrival and departure, and restricts youth access to the work area. To assist in this procedure, the program utilizes a contractor tool inventory verification sheet. These sheets were reviewed from July 2019 to January 2020. The sheets captured the name of the outside contractor, their agreement to inventory tools in their possession, signature of the contractor, signature of a staff who witnessed the inventory, and list of the tools brought to the program. The program's policy and procedures outline the shift supervisor approval of all tools used by contractors. The dates of the project from invoice matched the sign-in sheets.

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

The program provided documentation of each fire, safety, and evacuation drill conducted. Drills were consistent with the Continuity of Operations Plan (COOP) and conducted monthly for each shift. The written facility operating procedures specify how drills are to be conducted. Documentation of all drills contained the type of drill, date and time of the drill, participants, brief scenario, and findings/recommendations. The program provided the debriefing documentation, verifying separate events of the drills. An interview with the program director revealed the program conducts drills on a regular and routine basis. Emergency drills involving multiple situations were conducted on December 4, 2019, November 10, 2019, December 17, 2017, September 25, 2019, July 6, 2019, and August 13, 2019. Five staff and five youth were interviewed on what drills they have participated in within the last twelve months. Each staff reported weather, major disturbances, bomb threats, hostage situations, chemical spills, flooding, escapes, and fires. All youth reported they have been instructed on what to do in the event of a fire. The youth also reported fire drills have been performed at least monthly at the program.

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 coordinated disaster plan and Continuity of Operations Plan (COOP). The COOP was approved on March 19, 2019. The plan addresses alternative housing plans, which were approved by the Department's north regional director. The program director reported the COOP is located in the central staff cabinet of the main office, where all staff have access.

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 director maintains strict control of flammable, poisonous, and toxic items and materials and a complete inventory of all such items. They are maintained in a double-locked storage unit in the vocation building. All flammable, poisonous, and toxic material were stored securely. A review of the flammable, poisonous, and toxic items and materials inventory and determined each was accounted for and there were no items on-site which were not on the inventory Safety Data Sheets (SDS) list.

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

The program maintains a strict control of flammable, poisonous, and toxic items and materials by utilizing a double-locked storage unit in vocations and an inventory sheet. Youth are not permitted to use, handle, or clean with dangerous or hazardous chemicals or respond to chemical spills. The program's written facility operations procedures clearly stated youth are not permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids,

or human waste. Five youth were interviewed as to what chemicals, if any, they have utilized in the program. Four of five reported using none. One youth reported having used rubbing alcohol. The youth interviewed did not reflect whether staff sprayed the chemical and had the youth wipe it off.

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.	

All flammable, toxic, caustic, and poisonous materials are stored in secure areas inaccessible to youth, in a double-locked storage shed, including substances labeled “Keep out of the reach of children” or “May be harmful if swallowed.” Hazardous materials are disposed in accordance with the manufacturers’ Safety Data Sheet (SDS) according the written facility operations procedures (FOPs). Designated containers for hazardous liquid waste are stored in the same hazardous materials storage area. Liquid waste not resulting from work are disposed of in the plumbing area according to observations including liquid waste resulting from work. The FOPs addresses when chemical spills occur, the following actions are to be taken. Upon becoming aware of a chemical spill, staff shall notify master control of the location, the shift supervisor/master control shall direct the shutdown of all air handlers and ventilation systems and close all windows and doors at the direction of the on-scene supervisor, and assistance from outside the facility shall be contacted, as necessary, consistent with emergency procedures. An interview with maintenance staff determined flammable, toxic, caustic, and poisonous items and materials are disposed of by utilizing the military disposal system. The FOPs includes disposal of hazardous items and toxic substances or chemicals in accordance with Occupational Safety and Health Administration standards. A review of the program’s disposal log determined there has not been a need for the disposal of any material during the annual compliance review period. The program director was interviewed and stated the maintenance personnel places items on the disposal list and transports material to the jail for hazardous material disposal.

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

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

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

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

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

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

The program does 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's visitation schedule is posted as 10:00 a.m.to 12:00 p.m. on Saturday and Sunday. The program's written policy and procedures were reviewed as it relates to visitation, youth correspondence, and use of telephone. The visitation log and schedule, telephone log, and correspondence log were reviewed and are consistent. Alternative visitation is available with the youths' parent/guardians. Youth can communicate with family by mail and telephone. Three youth were interviewed and each indicated they can mail two letters a week and have unlimited legal correspondence. The five interviewed youth stated they are allowed one call a week from the approved list. All five youth reviewed had call logs within their records.

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

The program has written policy and procedures in place addressing search and inspection of the controlled observation room, controlled observation, and controlled observation safety checks and releases. The program did not have any controlled observation incidents during this annual compliance review period.

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

The program has written policy and procedures in place addressing search and inspection of the controlled observation room, controlled observation, and controlled observation safety checks and releases. The program did not have any controlled observation incidents during this annual compliance review period.

5.25 Controlled Observation Safety Checks Release Procedures	Satisfactory Compliance
The program shall conduct safety checks for youth on Controlled Observation. The 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 written policy and procedures in place addressing search and inspection of the controlled observation room, controlled observation, and controlled observation safety checks and releases. The program did not have any controlled observation incidents during this annual compliance review period.

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

Reviewed documentation reflected the program developed a program-specific Safety Plan form which identifies stimuli which included positive and negative effects on the youth. The program's Safety Plan form included an initial planning process and a review planning process. The initial planning process is initiated by each youth's case manager within fourteen days of the youth's admission to the program. The safety plans are jointly prepared by the youth, parent/guardian or family member, case manager, and clinical staff. The plans are reviewed and signed by all staff involved and the youth. The youth's safety plans are updated every thirty-days to include signatures and the date of the youth and staff. The program's Safety Plan form included the youth's warning signs, baseline behaviors gathered from collateral contacts, crisis recognition, jointly developed coping strategies, intervention strategies, and debriefing preferences. Five youth safety plans were reviewed and each were updated every thirty-days and followed any significant behavioral or mental health event identified by the youth's intervention and treatment team. All five youth safety plans incorporated recommendations of previous and current clinical assessments as required. The youth's safety plans were maintained in the youth's mental health

records and within a centralized binder inside the master control room easily accessible to all staff. Five youth were interviewed and each reported they knew the process for reviewing their safety plan. Five staff were interviewed and each reported they knew the process for reviewing their safety plan.