STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Crestview Youth Academy - Nonsecure
Youth Opportunity Investments. LLC
(Contract Provider)
449 StraightLine Road
Crestview, Florida 32539

Review Date(s): February 12-15, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; or limited, unintentional, and/or non-systemic exceptions that 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 that 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 that 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:

Lea Herring, Office of Program Accountability, Lead Reviewer (Standard 1)
Lytha Belrose, Office of Residential Services, Program Area Liaison (Youth and Staff Interviews)
Tara Frazier, Office of Program Accountability, Regional Monitor (Standard 5)
Jessica Gibson, Office of Programming and Technical Assistance, Technical Assistance Specialist (SPEP)
Randy Hardin, Juvenile Unit Specialized Treatment, Clinical Coordinator (Standard 3)
Julie Johnson, DJJ Probation, Circuit 1, Senior Juvenile Probation Officer (Standard 2)
Juan Youman, Office of Program Accountability, Regional Monitor (Standard 4)

Program Name: Crestview Youth Academy-nonsecure
Provider Name: Youth Opportunity Investments, LLC
Location: Okaloosa County / Circuit 1
Review Date(s): February 12-15, 2019

MQI Program Code: 1441
Contract Number: 10210
Number of Beds: 24
Lead Reviewer Code: 127

Methodology

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.

Persons Interviewed

- ☒ Facility administrator
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- _____ # Case Managers
- **3** # Clinical Staff
- **1** # Food Service Personnel
- **3** # Healthcare Staff
- **1** # Maintenance Personnel
- **3** # Program Supervisors
- **3** # Staff
- **5** # Youth
- _____ # Other (listed by title): _____

Documents Reviewed

- ☒ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☐ Confinement Reports
- ☒ Continuity of Operation Plan
- ☒ Contract Monitoring Reports
- ☒ Contract Scope of Services
- ☒ Egress Plans
- ☐ Escape Notification/Logs
- ☒ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☒ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Sick Call Logs
- ☒ Supplemental Contracts
- ☒ Table of Organization
- ☐ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☒ Visitation Logs
- ☒ Youth Handbook
- **5** # Health Records
- **5** # MH/SA Records
- **21** # Personnel Records
- **10** # Training Records/CORE
- **3** # Youth Records (Closed)
- **5** # Youth Records (Open)
- _____ # Other: _____

Observations During Review

- ☒ Admissions
- ☐ Confinement
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☒ Group
- ☒ Meals
- ☒ Medical Clinic
- ☒ Medication Administration
- ☒ Posting of Abuse Hotline
- ☒ Program Activities
- ☒ Recreation
- ☒ Searches
- ☒ Security Video Tapes
- ☒ Sick Call
- ☒ Social Skill Modeling by Staff
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Transition/Exit Conferences
- ☒ Treatment Team Meetings
- ☒ Use of Mechanical Restraints
- ☒ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.

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	Non-Applicable
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	Failed
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

* 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	Limited
2.07	R-PACT Assessment and Reassessments	Satisfactory
2.08	Youth Needs Assessment Summary	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	Limited
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	Satisfactory

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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	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Room Restriction/Controlled Observation	Satisfactory
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff 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 Handlins 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	Recreation and Leisure Activities	Limited
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Failed
5.25	Controlled Observation	Satisfactory
5.26	Controlled Observation Safety Checks and Release Procedures	Limited

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Program Overview

The Crestview Youth Academy Borderline Developmental Disability (BDD) and Developmental Disability (DD) Non-Secure Program is a twenty-four bed program, for thirteen to eighteen-year-old males, located in Crestview, Florida. The program is operated by Youth Opportunity Investments, LLC, through a contract with the Department and is co-located with Crestview Youth Academy Substance Abuse Secure Program. The program provides the following services: developmental disability treatment services and borderline developmental disability, through providing the delinquency intervention service of Impact of Crime and Male Healthy Relationships groups. Additional mental health treatment services provided includes individual, family, and group therapy sessions. These services provide youth with social and life skills training, victim impact awareness, recreation therapy, and restorative justice programming. Program administration is comprised of one facility administrator and two assistant facility administrators. Case management services are provided by three case managers and one transition case manager. Mental health staff at the program includes one designated mental health clinician authority (DMHCA) who is the clinical director, one assistant clinical director, four mental health therapists, and a contracted psychiatrist who provides psychiatric services bi-weekly. Medical services are offered Saturday through Friday and are provided by three full-time registered nurses (RN) to include a contract with a medical doctor (MD) who serves as the program's designated health authority (DHA). Educational services are provided by the Raider Group, which is contracted by the Okaloosa County School District. At the time of the annual compliance review, the program had four vacant positions including one human resource specialist, one therapist, one recreation therapist, and one master control operator. The layout of the program includes one building which contains two dormitories, kitchen and cafeteria, education classrooms, medical unit, and case management, therapists, and administrative offices. The program has thirty-two security cameras, twenty-seven of which are operational in providing coverage.

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. A contract provider may hire an employee to a position that 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 that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

Twenty-one staff records were reviewed for initial background screening requirements, based on the program's staff list and date of hire (DOH). The program has a written policy and procedures in place which states a staff may be hired to a position requiring a background screening before the screening process is completed, but only for training and orientation purposes. These staff shall not have contact with youth until the screening is complete. One staff was listed with a DOH on December 22, 2018; however, this staff was transferred to the program from another program ran by the same provider. The facility administrator (FA) was able to show documentation of the staff's original DOH in 2016. Four of the twenty staff received a background screening prior to the DOH. Sixteen staff records had a background screening completed after the staff's DOH. An interview with the FA found the program adheres to their policy and will not allow staff to have any contact with youth until both the screening and training are completed. Additionally, there were six newly hired staff which could not be reviewed because they had pending background screenings. One background screening came in during the annual compliance review with an eligible rating. A review of shift briefing reports, with the list of staff working each day on each shift, was reviewed. The shift briefing reports confirmed direct care staff, who were hired prior to the completed screening, did not have contact with youth until after the screening was completed. One of the four staff, who's background screening was pending, worked in master control two days. An interview with the master control operator reported they do not rotate with floor staff at all and do not have contact with youth while working in master control. All staff who had a completed background screening, received an eligible rating and were screened through Clearinghouse. The program also added the staff to the Clearinghouse roster. The FA provided thirty-three pre-employment assessments and passing scores. The FA reports they have two volunteers at the program, but neither volunteer is present at the program for more than ten hours a month and they are always under staff supervision. The program submitted the Annual Affidavit of Compliance with Level Two Screening Standards (Form IG/BSU-006) January 10, 2019, meeting the annual requirement. The program submitted the Affidavit of Compliance with Level Two Screening Standards for school board personnel on January 10, 2019, also meeting the annual requirement.

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

The program has a written policy and procedures which addresses background re-screenings. The program's policy states all staff will receive a background rescreening every five years from the date of their initial employment and service. The provider has been running Crestview Youth Academy for less than five years and none of the staff on the list submitted had a hire date that would require a five-year rescreening.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.* • *All allegations of child abuse or suspected child abuse are 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.* • *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.*	

The program has a written policy and procedures which addresses provisions for an abuse-free environment. The policy ensures staff will provide youth unhindered access to report alleged abuse allegations. Staff shall provide telephone access to report all allegations of abuse. The policy further states at no time should youth be prevented from self-reporting or making a call to the Florida Abuse Hotline or the Department's Central Communications Center (CCC). In the event a youth chooses to make an abuse call, the shift supervisor and facility administrator must be notified immediately of the youth's request. Staff will assist the youth in placing the abuse call, dialing the telephone number, recording the date and time of the call, obtaining the operator number, and document on the internal incident report form. Staff are to maintain sight of the youth, while keeping the youth in an area which allows for him to freely and confidentially report allegations. All staff are required to sign for, receive, and adhere to a Code of Conduct. A copy of the employee handbook was provided which included a staff standard of conduct. Staff handbook signatures were provided, which indicates the program's standards for ethical conduct were explained to the staff and staff signed a receipt of acknowledgement for the employee handbook. Observations made during the annual compliance review found evidence

the Florida Abuse Hotline number was posted throughout the program and in youth living areas. This number, along with the number for the CCC were included in each youth handbook. All youth sign for and receive a youth handbook upon admission to the program. A review of the youth handbook also found evidence of the abuse reporting procedures for youth. The program reported having no allegations of physical, psychological, or emotional abuse by staff since the last annual compliance review. Three staff were interviewed and asked to explain the process in the event a youth chooses to call the abuse registry. Three staff reported to notify the supervisor, two staff reported to notify the facility administrator, one staff reported to allow the youth to make the call, three staff reported the supervisor makes the call, and none of the staff reported the staff make the call. All three staff denied ever observing a co-worker tell a youth they could not call the Florida Abuse Hotline. All three staff denied ever hearing a co-worker using profanity or threats directed towards a youth. Five interviewed youth all reported they feel safe in the program. All five youth reported the program does not stop youth from reporting abuse if requested. Four interviewed youth reported staff were respectful when speaking with them and other youth and one youth stated, “Sometimes, everybody has their moods.” Four youth reported they have never heard staff use curse words when speaking with them or others and one youth reported occasionally. The facility administrator was interviewed and stated, “While not intended to list all the forms of behavior that are considered unacceptable in the workplace, rule infractions or misconduct result in disciplinary action, including termination of employment.” The facility administrator was asked to explain the program’s incident reporting process and responded to contact an administrator as soon as possible with details of the incident. Florida Director is also made aware of the incident. Administration will then determine if it’s a reportable incident based on the Administrative Rule. A call has to be placed within two hours of gaining knowledge. If it’s a staff related issue, that requires the accused staff to be removed from all youth contact pending the results of an investigation. Abuse registry, parent notification, documentation in the logbook, incident report, and call to the Central Communications Center (CCC).

1.04 Management Response to Allegations (Critical)	Non-Applicable
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 has not had any allegations of physical, psychological, or emotional abuse during the scope of the annual compliance review; therefore, this indicator rates as not applicable.

1.05 Incident Reporting (CCC) (Critical)	Satisfactory Compliance
Whenever a reportable incident occurs, the program notifies the Department’s Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.	

The program has a written policy and procedures which addresses incident reporting to the Central Communications Center (CCC). Three of the five reviewed CCC reports were called to the CCC within the required two-hour timeframe; the remaining two reports were substantiated as failures to report within the CCC system. A review of the program’s facility log book found evidence showing all incidents reported to the CCC were logged. The program maintains a record of each CCC report within a binder, along with the corresponding internal incident report attached. A review of grievances and incident reports did not yield any additional information

which should have been reported to the CCC. When asked how the program ensures staff and youth are knowledgeable on contacting the Florida Abuse Hotline/CCC, the facility administrator reported, “Daily Morning meetings report out any CCC and/or Abuse calls within the facility for the management team. Monthly All Team Meetings cover CCC and Abuse Hotline information. Youth are reminded in weekly Townhouse Meetings. Staff and youth also have postings that explains the process for CCC and Abuse Hotline information.”

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

The program has a written Protective Action Response (PAR) plan which was approved by the Department on January 22, 2019. The program submits statistical data to the Department’s Residential Operations, which includes a monthly summary of all PAR incidents, by the fifteenth of each month. The program’s current PAR rate is 3.66, which is above the statewide average of 1.47. Five PAR incident reports were reviewed for completion and accuracy. Four of the five incidents reviewed were completed by the end of the staff member’s workday. Two of the five had signatures from administration dated the day after the incident, which included the post-PAR interviews with the youth. The post-PAR youth interview is required to be completed within thirty minutes after the incident. However, with the signature being dated the next day, it was difficult to determine whether the post-PAR interviews were completed within the thirty-minute timeframe. Four of the five reports included statements from all staff involved. One of the incident reports had four staff listed with three staff statements, and two staff who were not listed on the PAR report provided statements. None of the reviewed PAR incidents included the use of mechanical restraints, allegations by the youth to the Florida Abuse Hotline, nor any injuries to the youth involved. Each of the five PAR reports were reviewed by a PAR certified instructor or supervisory staff. Each report included a post-PAR interview conducted with the youth, and a review of the PAR incident by the FA or designee. The program maintains all completed PAR reports within a central file system. The facility administrator was interviewed and stated, “Crestview Youth Academy monitors PAR incidents and Use of Force by discussing with staff through Monthly All Team Meetings, shift debriefing, and as needed Coaching Sessions. If there is a youth who is continuously being involved in physical intervention Administrative provides feedback. The Treatment team makes all attempts to help youth with tools on how to be compliant in the program as in relates to his treatment.”

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

Five staff training records were reviewed for pre-service training requirements in the Department’s Learning Management System (SkillPro). Two staff (nurse and dietitian) were not required to complete Protective Action Response (PAR) or all of the suicide prevention training, but did complete On the Job Training (OJT), as was documented in SkillPro. Additionally, the nurse was not required to complete abuse reporting, grievance process, or Behavioral Management System (BMS) trainings. All five staff completed a minimum of 120 hours of pre-service training. A review of the trainings found evidence each staff was trained in

cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED). Each staff received training in professional ethics, emergency procedures, Prison Rape Elimination Act (PREA), contractually required training, infection control, and the exposure control plan. The three direct care staff completed Protective Action Response (PAR), all suicide prevention, child abuse reporting, grievance process, and BMS, as required. Four of the five staff received the specialized treatment training for Mental Health Overlay Services (MHOS). The staff missing the MHOS training was a direct care staff. Not all the training reviewed could be found in SkillPro, but the program was updating staff training in SkillPro during the annual compliance review. The program submitted a list of pre-service training to the Department's Office of Staff Development and Training which included course names, descriptions, objectives, and training hours for any instructor-led training February 7, 2019.

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

The program has a written policy and procedures which outlines objectives for in-service training requirements. All five reviewed in-service staff training records indicated each of the staff received more than the required twenty-four hours of training. All of the records contained documentation of completed training in cardiopulmonary resuscitation, first aid, automated external defibrillator (AED), Protective Action Response (PAR) refresher training, professionalism and ethics, suicide prevention, and the additional contractually required trainings. Additionally, all five in-service training records were complete for grievance process, suicide prevention, emergency response, and the specialized treatment training for Mental Health Overlay Services (MHOS) and Development Disabilities Treatment Services. Four of the five staff completed infection control, blood-borne pathogens, and exposure control plan. Three of the five staff completed behavior management system training. The program was unaware of incomplete or missing training and explained this was an oversight. Three supervisors were reviewed for the required eight hours of additional supervisory training. All three supervisors completed the additional supervisor training. However, one of the supervisors completed the remaining three hours supervisory training January 1, 2019. The program submitted a list of in-service training to the Department's Office of Staff Development and Training, which included course names, descriptions, objectives, and training hours for any instructor-led training on February 7, 2019.

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

The program has a written policy and procedures which includes training requirements for the grievance process. The program's grievance process includes an informal, formal, and appeal phase. Observations made during the annual compliance review revealed the program

maintains a locked box for youth to place completed grievances within. Two grievances were submitted by youth within the six-month annual compliance review period. Both grievance forms were reviewed and were settled in the formal phase within the required timeframes. Each grievance contained the youth's signature to verify the youth was satisfied with the result of their grievance. Five in-service and five pre-service training records were reviewed, and each indicated training was completed in the grievance process.

Five youth were asked to explain the grievance process and three youth responded they had not submitted a grievance. Two youth reported you can fill out a grievance anytime you want. One youth states you can give it a supervisor or facility administrator and it takes twenty-four hours to get a response. One youth reported staff give you a pen and you can put it in the box. All five youth reported staff can assist in filling out a grievance. Three staff were interviewed and asked to explain the grievance process. All three staff reported forms are placed throughout the program, youth can request assistance in completing the form, supervisor reviews grievances, and facility administrator reviews grievances.

1.10 Delinquency Interventions and Facilitator Training	Failed Compliance
The program shall implement a delinquency intervention model or strategy that is an evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. Staff whose regularly assigned job duties include implementation of a specific delinquency intervention model, strategy, or curriculum receive training in its effective implementation.	

A review of the provider's contractual agreement and interviews with clinical staff revealed Impact of Crime (IOC) is the delinquency intervention service provided for the non-secure population of the program. The IOC curriculum is a promising practice with demonstrative effectiveness. Group sign-in sheets were reviewed to confirm the groups were held. It was determined approximately eighty-six percent of the youth participating in an IOC cohort held between the months of May to September of 2018, were released from the program prior to the completion of IOC. Then a break in service took place from September 2018 to February 2019, where no IOC groups were held. An IOC group began the week before the annual compliance review. Two staff, who facilitate these groups, received certifications for the delinquency interventions provided for youth. The two staff had the required education and years of experience in working with adult or juvenile offenders. The education and experience are areas considered by the clinical director when determining staff delivery of delinquency intervention services. A review of the activity schedule determined the program has been providing structured, planned programming or activities at least sixty percent of the youth's awake hours.

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

The program has a written policy and procedures addressing life skills, social skills, and social rehabilitation provided to youth in the program. All staff shall reinforce and model appropriate social skills and behaviors. Staff are required to assist youth in the development of social and problem-solving skills. Life Skills Training (LST) groups are provided to the youth as part of their mental health treatment. A review of attendance logs and sign-in sheets confirmed groups were delivered as designed. Five reviewed youth records determined each youth was receiving

services as outlined in their performance plans. A review of staff training records found evidence all staff who provide groups have been trained and received certifications in LST. Youth within the program receive life and social skills training specifically addressing communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking, to include problem-solving and decision-making. The program conducts a general life skills/gender-responsive training based on various topics. All youth are eligible to receive these life skills groups.

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

The program's contractual agreement indicates the Impact of Crime (IOC) curriculum is used to provide restorative justice awareness to youth. A review of staff training records found both staff who facilitate IOC received training and certification in the curriculum. A review of the program's activity schedule, group sign-in sheets, and attendance logs confirmed groups were facilitated. It was determined approximately eighty-six percent of the youth participating in an IOC cohort held between the months of May to September of 2018, were released from the program prior to the completion of IOC. There was a break in service from September 2018 to February 2019, where no IOC groups were held. An IOC group began the week before the annual compliance review. The facility administrator was asked what restorative justice activities the youth participate and indicated IOC is held Tuesday and Thursday. Additionally, he stated youth assisted Liberty Church to help restore damage after Hurricane Michael, youth assisted with the Okaloosa little league pop warner, helped Life Pointe Church with a Coat Drive giveaway to the homeless, and helped clean up, organize furniture, and waxing floors during the summer for Davidson Middle School and Crestview High School as well as setting up for graduation in 2018.

1.13 Gender-Specific Programming	Satisfactory Compliance
The program provides delinquency intervention and gender-specific treatment services.	

A review of the program's contractual agreement determined the curriculum Seeking Safety is utilized as the program's gender-specific intervention. The program demonstrates the program model and designs its services based on the common characteristics of its male population. A review of the program's activity schedule and group sign-in sheets found evidence the program is providing the curriculum, as required. According to the program's written policy and procedures, the program has adopted the gender-specific curriculum Young Men's Work and Teen Relationships. The facility administrator also reported Male Healthy Relationship is bundled with the Young Men's Work and Teen Relationships as their gender specific delinquency intervention.

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

The program has a written policy and procedures which outlines the internal alert system, including steps for the review of alerts, and the discontinuance of alerts by authorized staff. The program maintains an alert board in their conference room where the shift briefings are usually held and is closed off to youth. The alert board included each mod and the room each youth was in on that mod. Next to the youth's last name was his Department identification number, date of birth, date of arrival, and the youth's behavior management system level. Additionally, there were columns which could be marked for victimization, single room/mental health, gang alert, medication, allergy, activity restriction, risk assessment, and escape risk. Color magnets which are designated for each alert can be placed on the corresponding alert column for each youth which requires an alert. Shift briefings forms have a designated space to list youth who are on alerts such as precautionary observation (PO), escape risk, or physical restriction. A review of the shift briefing forms revealed youth entering the program on PO were listed on the shift briefing forms. Alerts for youth with medical alerts or alerts for food allergies are posted within the kitchen area for dietary staff to review. Three staff were interviewed on how staff are informed of alerts. All three staff reported the alert board is reviewed every day before the shift. Other comments were emails, shift reports, and for new admission youth with alerts; a form is signed.

A review of the Department's Juvenile Justice Information System (JJIS) found alerts within JJIS matched those posted on the internal alert system for the five youth records reviewed. However, one of the five records included a youth with an asthma alert entered in 2016, which was updated in 2017, prior to the youth's arrival at the program. There was not a note in JJIS found from the program staff, nor an asthma alert listed on the program's internal alert system. A check with annual compliance review team member reviewing standards for mental health, medical, safety and security, and case management found no discrepancies for alerts within JJIS or the internal alert system. Each of the alerts were updated by the appropriate staff. The facility administrator reported each department head is responsible for inputting and closing any information in JJIS. The alert board is located in the conference room. Management reviews alerts daily and/or as information changes.

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

The program has a written policy and procedures to ensure the consistent and effective management of all records which adheres to the guidelines and contractual requirements. The program separates youth records into to separates files: and individual healthcare record and an individual management record. The file tab on the individual management record contained the following information: youth's name, Department number, date of birth, county of residence, and committing offense. The individual management record contained the following sections: legal information, demographic and chronological information, correspondence, case managements and treatment team activities, and a miscellaneous section. All youth records observed during the annual compliance review were labeled "confidential." The program stores youth records in secure cabinets marked "confidential" and youth do not have access to these areas.

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

The program's written policy and procedures reflects the program ensures youth have a voice within the program and are included in part of program decision making through the Youth Student Council. Youth Student Council meeting sign-in sheets were available for review. The sign-in sheets reflected the title of "in-house" meeting on the header and all sign-in sheets and meeting minutes are kept in a dedicated Youth Student Council binder. Documentation reflected meetings were consistently held bi-weekly and, in some instances, weekly. At any time, youth are also encouraged to utilize the program's Request to Speak forms if they have concerns, suggestions, or questions concerning the program. Three of the five youth interviewed in regard to providing program input and reported using Request to Speak forms, weekly meetings, talking directly to the facility administrator. The remaining two youth reported they don't really have the opportunity to provide input. According to the facility administrator, youth are given the opportunity to provide input through Request to Speak forms, Townhouse meetings, Advisory Board meeting, and during his day-to-day interaction with the youth.

1.17 Advisory Board	Satisfactory Compliance
The program has a community support group or advisory board meeting at least quarterly. The facility administrator solicits active involvement of interested community partners.	

The program has a written policy and procedures to ensure successful partnerships and community resources are utilized to enhance program service offerings. The program has a dedicated Community Advisory Board which meets quarterly. The Community Advisory Board binder, which contained sign-in sheets, meeting minutes, and pictures of events, was available for review. Documentation reflected meetings are held once every ninety days. The facility administrator solicits involvement from law enforcement, judiciary staff, community and business partners, school board or district, faith community, victim services, and parents of children previously involved in the juvenile justice system. Documentation in the form of letters in the Community Advisory Board binder reflected the solicitation of these participants, as well as the backgrounds of current members of the board. A board member was available for interview by

telephone and confirmed their members, meeting frequency and explained the type of events they had participated in. The facility administrator reported Community Advisory Board meetings are held quarterly and the board provides suggestions and ideas of how to assist the program and the youth.

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

The program has a written policy and procedures establishing a formal process for the monitoring and evaluation of quality, compliance, fidelity, appropriateness, safety, and effectiveness of program services using a proactive multidimensional approach. Satisfaction surveys are incorporated into the monitoring and verification activities as part of the program's quality assurance program. Satisfaction surveys are provided to youth, parents/guardians, and staff on a quarterly basis. Surveys target admission activities, topic specific assessments, and discharge satisfaction. Survey data is reviewed monthly at the program and corporate level and communicated to staff during monthly meetings. Results of the surveys are also included in Commission Accreditation Reports (CAR). The program's Morale Binder was available for review. This binder is dedicated to the staff Morale Committee. Documentation reflected monthly meetings are consistently held. The Morale Committee is responsible for planning morale events for staff such as cookouts, potlucks, and team building activities. Staff are encouraged to provide input into events and overall program operation. The program conducts management meetings each morning, staff meetings monthly, and shift briefings are held daily. Management also ensures they recognize staff through awards during staff recognition days. Three staff were interviewed in regard to the frequency of staff meetings and reported meetings are held monthly, daily, and weekly. Further, staff reported meeting topics included youth, alerts, changes in operations, staff morale, and things we need to work on. Two staff reported they were briefed on CAR reports and surveys and one staff reported they did not receive this information. All three staff reported communication amongst staff at the program is good. According to the facility administrator, daily meetings are held and information concerning the program is collected from surveys, family sessions, individual sessions, and treatment team meetings. He further reported competition in area is the biggest factor in staff turnover. To combat staff turnover, the program has increased morale functions and staff acknowledgements such as awards.

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 outlining the program's system for evaluating staff, performance standards, and the frequency of evaluations. According to the written policy and procedures, staff receive an evaluation within the first ninety days of employment and annually thereafter. A sample position description was available for review. The sample position description reflected performance standards were clearly identified. Sample staff evaluations reflected performance evaluations were completed within the first ninety days of employment and on an annual basis. A review of the contract reflected all key positions are currently maintained and being evaluated with the exception of the recreational therapist. The program's previous recreational therapist's employment ended in October of 2018 and the program is currently advertising this position. According to the facility administrator, all staff are provided evaluations. Three staff were interviewed in regard to the frequency of staff evaluations. One

staff reported evaluations are conducted monthly. Two staff reported evaluations are completed yearly.

Standard 2: Assessment and Performance Plan

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

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

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

Each of the reviewed five case management records found orientation took place within twenty-four hours of each youth's admission to the program. The orientation process covered program rules and expectations, goals of the program, and services that are available. Staff also provided youth information about searches, contraband, community access, living assignments, visitation, the Florida Abuse Hotline number, grievance procedures, dress code, and performance planning. In all five records reviewed, the youth initialed all boxes to indicated understanding; however, one of the five records did not have the explanation of performance planning checked off by the youth. All five interviewed youth confirmed orientation to the program began within twenty-four hours of arrival and the program's rules, procedures, schedules, etc. were all explained to them.

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

Three of the five reviewed youth records were for youth who were eighteen years old or older at the time of admission to the program. In the three applicable records, written consent forms signed by the youth, were obtained before releasing any information relevant to the youth's treatment, assessments, and screenings to parents/guardians.

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 that may be used as potential weapons or means of escape, or participation in any off-campus activity.*	

Five case management records were reviewed for classification factors, procedures, and reassessments for activities. Staff administered assessments on the day of admission to determine the appropriate classification for each of the five youth. The screening assessments covered the elements required by policy which include special needs, maturity, physical characteristics, age, history of violence, gang affiliation, escape risk, suicide risk, and security risk. Each of the five records also contained a completed Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening instrument to determine suitable placement in the living units. All five youth records reviewed were applicable for reassessments and their classifications were updated accordingly.

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

Five case management records were reviewed for notification to law enforcement regarding gang identification for youth admitted to the program. Three of the five youth reviewed were identified as gang members. Staff completed a gang assessment as part of the orientation into the program at the time of admission. One of the three youth who was subsequently identified as a gang affiliate was not identified during orientation based on the answers he gave during assessment; however, he made admissions to the gang liaison, at a later time. The gang liaison presented a binder which contained documentation showing notification was made to the appropriate law enforcement agencies. No evidence was provided that the school district was given notification of gang affiliation. The gang liaison reported an email is sent to the school district, but no email copies were provided.

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

Five case management records were reviewed to assess if the program is providing intervention strategies to youth identified as gang affiliated, members of a criminal street gang, or youth who are identified as a high risk for involvement in gang activity. Three of the five youth were identified as either gang members or affiliated with gang activity. Two of the three youth's performance plans did not contain goals related to gang interventions. After speaking with the gang liaison, a sign-in sheet was provided documenting the attendance of all three youth at the

gang intervention group. This documentation was not found in the youth's case management records.

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

Five case management records were reviewed for compliance regarding initial assessments within thirty days of admission to the program. All five records showed that the Residential-Positive Achievement Change Tool (R-PACT) was conducted within the thirty-day timeframe and maintained in the Department's Juvenile Justice Information System (JJIS). All five records also reflected R-PACT Reassessments were completed within the ninety-day time limit, or as-needed if a change in interventions were needed prior to the ninety days. All five records contained documentation of the initial assessment and subsequent assessments.

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 YNAS.	

Five youth records were reviewed to determine if a Youth Needs Assessment Summary (YNAS) was completed and documented within thirty days of admission to the program. All five records showed staff conducted the YNAS within the allotted timeframe and documented the assessment in the Department's Juvenile Justice Information System (JJIS), as required. One of the youth had a YNAS done on time, but the supervisor did not approve it until thirteen days later which affected the timeliness of the YNAS being entered into the JJIS for documentation purposes.

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

Five youth records were reviewed for compliance regarding the development of performance plans by the treatment teams within thirty days of admission to the program. All five

performance plans were developed and signed by the treatment team. The treatment teams consisted of the treatment leader, youth, an administrative representative, living unit representative, treatment staff, and education staff. All five performance plans were developed after the initial assessment, as required. One youth's performance plan showed a date of May 17, 2017, for its development. This date was originally from when the youth was in a program prior to Crestview Youth Academy and had not been changed to a date after the youth was admitted to the program. Each of the five plans contained goals which were individualized based on the risk factors and protective factors outlined in the initial assessment process. All five plans also addressed the youth's top three criminogenic needs, as recommended. Each of the five performance plans contained action steps for the youth and program staff to complete in order for youth to reach their goals and target dates. A copy of the completed plans were provided within ten working days to the parents/guardians, youth, and juvenile probation officers; however, the committing court was only sent a copy of the plan in two of the five records reviewed. Two of the five interviewed youth stated they were provided a copy of their performance plan.

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

Five case management records were reviewed for proof of revisions to the performance plan. Three of the four applicable youth records had RPACT changes and newly acquired information. All had made progress towards completing the goals. Three of the five youth records included transition activities.

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.*	

Five records were reviewed and one of the youth qualified for performance summaries which contained transition goals, so another two closed youth records were provided and reviewed. The reviewed performance summaries all included the status of each youth's goals, youth behavior progress, interactions with staff, adjustments to the program, and justifications for release. All ninety-day summaries were completed within ninety days with the exception of one summary for two youth, which were not completed. None of the three records reviewed had documentation of youth interaction with peers in the program and were also missing grades for each of the youth's classes although overall academic progress was provided. Documentation was present in all three records showing the youth, juvenile probation officer (JPO), and parents/guardians were provided a copy of the performance summaries. Two of the three records contained documentation indicating the committing court was provided a copy of the summary within ten working days along with the Pre-Release Notification (PRN). All three records contained documentation showing written notices of the youth's pending release were

sent to the parents/guardians and JPOs. Two of the three youth records reviewed were released from the program and had a Residential Positive Achievement Change Tool (RPACT) Exit Assessment done within the required timeframe. The third youth did not have a completed Exit R-PACT. The program also provided all three of the youth's JPOs with a copy of their performance summary, physical health summary, and transition plan. Victim notification letters were not provided in the two applicable records. One of the five interviewed youth reported they received a copy of the performance summary sent to court.

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

Five records were reviewed for parent/guardian involvement in the case management process. All five youth records showed parent/guardian participation in the assessment process, progress reviews, transition planning, and treatment team meetings. Parents/guardians in all five records were provided the opportunity to participate by phone/video if they were unable to attend in person after receiving written notice from the program about times and dates of meetings. Five youth responded their parents/guardians were involved in case management, treatment plans, and treatment teams when interviewed.

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.	

Five records were reviewed to ensure treatment teams were comprised of various staff from the program. All five records reviewed had documentation of participation from a treatment team leader, youth, a living unit representative, treatment staff, education staff, juvenile probation officer (JPO), parent/guardian, and a representative from administration.

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.	

Five performance plans were reviewed for the incorporation of academic and treatment plans into the youth's performance plans. None of the records reviewed were applicable for requiring a behavior support plan through the Department of Children and Families or Agency for Persons with Disabilities.

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include R-PACT 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 progress. *A residential commitment program shall ensure the intervention and treatment team reviews each youth's performance, including R-PACT 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 progress.*	

Five case management records were reviewed for documentation of the treatment team process. All five of the records contained documentation showing treatment teams occurred in a formal capacity every thirty-days with documentation of the required meeting attendees were confirmed in the form of a signature-in sheet. There was also documentation in all five records indicating performance plan revisions took place as-needed. Each treatment team documented the youth's treatment progress, Residential Positive Achievement Change Tool (RPACT) results, and progress toward performance plan goals. There was documentation indicating all appropriate parties were invited to participate in the meetings, to include the juvenile probation officer (JPO), parent/guardian, and relevant stakeholders.

Informal treatment team reviews took place every two weeks, as required, for all five youth. Documentation included the youth's treatment progress and discussed skills the youth acquired in the program. Five youth were asked if they are given an opportunity during treatment team meetings to demonstrate any skills learned and four youth replied they did. One youth responded no and further commented treatment team is every two weeks, the program does not ask him to demonstrate anything, and he only remember going to treatment team two times.

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

The program provides Type 2 educational programming which is based on each youth's age, length of stay in the program, and their assessed educational abilities and goals. Career education programming includes training in communication, interpersonal, and decision-making skills. Only one of the five reviewed records was applicable for youth with employability as a goal; therefore, two additional closed records were reviewed. All three records contained resumes summarizing youth's skills and experience, documentation of appointments with the youth's local Career Source Center, and appropriate documents essential to obtaining employment. Two of the three records also included completed job applications. Each of the records also included documentation indicating the youth's parent/guardian and juvenile probation officer were made aware of the youth's vocational plan.

2.17 Educational Access	Limited 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.	

Various documentation was reviewed to determine compliance for educational access including logbooks, observation during the day, school schedule, video footage to validate times/dates, and interviews with the principle and facility administrator. The school is required to provide 300 minutes a day of educational instruction to youth for five days a week, Monday through Friday. The documentation reviewed did not support youth are attending school for the required 300 minutes a day. Five days were originally reviewed; however, it was determined two of the days were teacher planning days and school ended early, so an additional two days were selected and reviewed. Only one of the seven days selected met the approximate required hours for classroom instruction. All logbook entries documented the youth arrived at class anywhere from fifteen minutes to approximately two hours late. Six of the seven days reviewed in the logbook, had no documentation of youth movement back to class after lunch. On the six days with limited classroom hours, entries in the logbook only documented other activities in the afternoon. The principal said he was unaware of these infractions since he has three schools he supervises at different facilities. When interviewed, the facility administrator appeared to be surprised by the lack of classroom time documented, but did not have any explanation as to why there were huge gaps in verifying the youth's classroom instruction in the afternoons. One of the five youth interviewed responded yes, to being asked if there are a lot of interruptions during educational instruction.

2.18 Education Transition Plan	Satisfactory Compliance
Staff and youth complete an education transition plan upon entry including provisions for continuation of education and/or employment.	

Three case management records were reviewed to determine if the transition plans contained appropriate youth goals, once released from the program. Each of the three closed youth records reviewed had an education plan which was developed with the youth, parent/guardian, and education staff. The plan also included educational placement upon returning to the community. None of the three records outlined specific responsibilities for the parties involved in coordinating support services for the youth in the community. Two of the three youth were released from the program and obtained valid Florida Identification Cards prior to leaving the program. The two youth records included appointment information to visit a career center in their local area.

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.*	

Three closed case management records were reviewed for youth who were ready to participate in transition activities and a Community Re-entry Team (CRT) meeting prior to being released from the program. During the initial review for transition planning, there was no documentation in the records showing a CRT meeting was conducted or that the youth participated in a CRT meeting. Documentation was later provided by the transition coordinator, who said most of the correspondence for the CRT meetings took place in emails. The two youth who had CRT meetings participated along with their case manager which was documented through email. Copies of the emails were provided but were not contained in the case management records. Two of the three transition conferences were not conducted within sixty days prior to the youth's scheduled release. One of the conferences took place fifty-three days prior to release and the other one, which did not meet standards, took place forty-five days prior to release. All three of the records contained documentation indicating the appropriate parties were invited to the transition conference and participated. During the conference, all three records showed the performance plan and target dates were reviewed, as well as the transition activities.

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.	

Three closed case management records were reviewed to ensure the program properly assembled an exit portfolio for each youth to take into the community upon release. Each of the three closed youth records reflect the exit portfolio was discussed at the transition conference, as required. All three of the exit portfolios contained a State of Florida identification card, a copy of the youth's transition plan, education records, a calendar of appointments in the community, a resume, transcripts, and a sample job application. Two of the three exit portfolios did not contain a birth certificate or social security card. All three youth were provided a copy of the exit portfolio to take with them and a copy was forwarded to the juvenile probation officer (JPO).

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 case management records were reviewed to determine if all of the required elements for the exit conference were present. Two of the three records did not contain documentation indicating the juvenile probation officer (JPO) was invited to participate in the exit conference. All three exit conferences took place within fourteen days of the youth being released from the program. There was documentation that the transition activities were reviewed and finalized by the attendees which included the youth, treatment leader, education representative, JPO, and parent/guardian.

Standard 3: Mental Health and Substance Abuse Services

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

The facility administrator is responsible for the administrative oversight and management of mental health and substance abuse services in the program. The program provides specialized treatment services and has 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 program. The DMHCA's license is clear and active and expires in 2020. An interview was conducted with the DMHCA and was asked to describe her role in the coordination and implementation of mental health and substance abuse services at the facility. She replied: I oversee clinical staff to include therapists, case managers, and recreation therapist. (The recreation therapist has been vacant since October 2018). She further states, she meets with the clinical team for supervision at a minimum of one hour weekly. She creates a weekly group schedule and reviews documentation for accuracy. She is on-site for a minimum of forty hours a week and on-call when off-site. She states, she meets with the psychiatrist weekly.

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

The program's mental health and substance abuse staffing is in accordance with the program's contract (10210) and Florida Administrative Code, 63N-1. The program has a licensed mental health professional; a licensed mental health counselor (LMHC), who serves as the designated mental health clinician authority (DMHCA), licensed under chapter 491, Florida Statutes. The program does not have any other licensed clinical staff, who work under the DMHCA supervision. The program has an independent contract agreement with a psychiatrist, who has completed a psychiatry program approved by the by the American Board of Psychiatry and Neurology, licensed under chapter 459, Florida Statute and meets all requirements outlined within Florida Administrative Code 63N-1. The psychiatrist's license is clear and active and expires January 31, 2020. The psychiatrist has specialties in pediatrics, child and adolescent psychiatry. A copy of the contract between Youth Opportunity Investments (YOI) and the psychiatrist was available for review while on-site. The program is licensed in accordance with Chapter 397, Florida Statute, to provide substance abuse services, certified by the Department of Children and Families (DCF). The programs licensure became effective August 14, 2018 and

will expire on August 13, 2019. Licensures for all qualified mental health and substance abuse professionals are available for review on-site.

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

The clinical supervisor assures each of the four non-licensed clinical staff are performing services each of them are qualified to provide based on education, training, and experience. All four non-licensed clinical staff hold the appropriate level of education necessary and are in accordance with the contract between the provider and the Department and Florida Administrative Rule 63N-1. Each of the four non-licensed clinical staff hold a master's-level degree from an accredited university. The program currently has one vacancy for a non-licensed clinical staff person. The clinical supervisor conducts weekly on-site, face-to-face interaction with each of the four non-licensed clinical staff; which are at least one hour for each contact. All face-to-face supervisions occurred as required. Each of the face-to-face supervisions conducted were recorded on a similar form to MHSA 019, which included all necessary information. The program is licensed under Chapter 397, to provide substance abuse treatment services; certified by the Department of Children and Families (DCF), which was effective August 14, 2018 and will expire on August 13, 2019. Each of the three non-licensed clinical staff have received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The non-licensed clinical staff's training was documented on the non-licensed mental health clinical staff person's training in Assessment of Suicide Risk (ASR) form MHSA 022

The licensed mental health professional, providing direct supervision reviewed and signed each of the five-comprehensive mental health and substance abuse evaluations completed by the non-licensed mental health clinical staff. There was documentation each of the five-initial mental health and substance abuse treatment plans, where the licensed mental health professional reviewed and signed, once completed by a non-licensed mental health clinical staff. There documentation to support the licensed mental health professional reviewed and signed all five-individualized mental health and substance abuse treatment plans prepared by the non-licensed mental health clinical staff. All reviews conducted by the licensed mental health professional of each of the non-licensed mental health clinical staff occurred within the specified timeframe. Two of five assessment of suicide risk (ASR) were completed by non-licensed mental health clinical staff, which were subsequently reviewed by the licensed mental health professional. The licensed mental health professional completed the other three remaining applicable ASR.

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.	

Each youth is administered the Massachusetts Youth Screening Instrument -Version II (MAYSI-2) and staff have the needed training to administer the screening and make referrals as needed. Five of five youth records contained the required MAYSI-2 screenings and related referrals.

Each of the MAYSI-2 screenings were conducted by trained staff on the day of each youth's admission. The program also uses the Assessment of Suicide Risk (ASR) to screen youth at intake and remove them from precautions if deemed appropriate.

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

Five of five youth records contained new comprehensive mental health and substance abuse evaluations completed within thirty days of admission. Each assessment included the identifying information, relevant background information, behavior observations, mental status examinations, discussion of findings, diagnostic impression including DSM diagnosis, and recommendations. All of the assessments were completed by non-licensed clinical staff and reviewed by a licensed clinical staff within ten days. Each record contained the needed requirements and related consent forms. Each of the five treatment plans had youth diagnosis documented with DSM IV diagnostic codes.

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

The multidisciplinary treatment team is responsible for assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans. The treatment teams observed did review the progress of the youth's performance and treatment goals and objectives. The multidisciplinary treatment team were comprised of the youth, program administration, staff from the residential living unit, and other staff responsible for delinquency intervention and treatment services for the youth. The youth were in receipt of one or more of the following; individual, group, family counseling, and or psychiatric medication management. In addition, each of the five youth records reviewed, were applicable for mental health treatment. The five-youth reviewed, each had a properly executed Authority to Evaluate and Treatment (AET) form contained within in their respective individual health care record. Each youth in receipt of services had documentation of a clinical impression to include diagnose from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) mental disorder. An interview was conducted with the program's designated mental health clinician authority (DMHCA). The DMHCA was asked, does the program offer any type of specialized services and, if so, how do you ensure these services are delivered in a manner consistent with contractual requirements. The DMHCA replied; we offer groups and individuals to address youth with developmental disabilities. In addition, the DMHCA was asked what clinical services are provided, she replied; group therapy, individual therapy, family therapy, and clinical supervision. Interviews were conducted with three staff. Each staff was asked, do you or other direct care staff facilitate any mental health or substance abuse groups; all three-staff replied, no.

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.*	

Youth 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. One youth record needed an addendum to update his treatment plan with a new diagnosis. Three discharged youth who receive mental health and/or substance abuse treatment while in the residential program have a discharge summary completed. The discharge summary documents the treatment focus, course of the youth's treatment, and recommendations for mental health and/or substance abuse services upon youth's release from the program. Three reviewed discharge summaries contained the needed elements and supporting documentation indicating they were copied to the youth, JPO and parent/guardian. Five of five youth records contained the required initial treatment plans. Each record also contained an individualized treatment plan. Three of the treatment plans address youth’s symptoms. Three staff were interviewed and asked if they facilitate mental health or substance abuse groups. Two staff stated no, one followed it up by saying licensed staff do groups, and one staff replied it depends on the group.

3.08 Specialized Treatment Services (Critical)	Satisfactory Compliance
Specialized treatment services shall be provided in programs designated as “Specialized Treatment Services Programs” or are designated to provide “Specialized Treatment Overlay Services.”.	

The program is contracted to provide specialized treatment for developmental disability and borderline developmental disability youth. The scope of developmental disability and borderline developmental disability treatment service delivery is outlined within the contract between the provider and the Department. Each youth committed to the program receives a developmental evaluation. After admission, each youth is in receipt of a bio-psychosocial assessment. Each youth is provided with a developmental disability treatment plan, which includes their developmental disability. Every youth’s individualized treatment plan goals are based upon each of their developmental needs. All youth receive daily activities, to include group, individual, and support treatment teams to address developmental needs. Each youth identified with co-occurring mental health and substance abuse disorders receive treatment specific to address their needs. The program is licensed under Chapter 397, Florida Statutes. The psychiatrist is on-site bi-weekly. The licensed psychiatrist provides psychiatric evaluations and medication management, as well as participates in treatment planning. The program has a mental health clinical staff on-site seven days a week. Counselor to youth ratio does not exceed ten youth.

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.	

The program has an independent contract agreement with a psychiatrist, who has completed a psychiatry program approved by the by the American Board of Psychiatry and Neurology, licensed under chapter 459, Florida Statute and meets all requirements outlined within Florida Administrative Code 63N-1. The psychiatrist's license is clear and active and expires January 31, 2020. The psychiatrist has specialties in pediatrics, child and adolescent psychiatry. A copy of the contract between Youth Opportunity Investments (YOI) and the psychiatrist was available for review while on-site. The program provides psychiatric services which include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling to youth with a diagnosed DSM-IV-TR mental disorder. Three of the five youth records reviewed were for youth who were admitted to the program with psychotropic medications. Two of the three youth also had changes to their medications post-admission. All three applicable youth received a psychiatric evaluation within thirty days of admission or referral. The Florida Department of Children and Family's consent forms for medications are available for review for one youth in foster care who was prescribed medications. No issues were noted with the psychiatric services provided.

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

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

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

The suicide response kits were observed and contained a knife for life, wire cutters, and needle nose pliers, as required. Each of the five reviewed youth records required suicide prevention services and youth were placed on standard supervision, maintained on precautions, or stepped down to close supervision. The program does enter alerts into the JJIS system and no youth were on active suicide alert at the time of the annual compliance review. All applicable alerts were entered and discontinued, as required, in the Department's Juvenile Justice Information System. Staff interviews reflect that staff know the suicide kits are located in master control and are participating in drills that may require crisis intervention/suicide prevention. No issues were noted with the suicide prevention services. No secure observations were available for review.

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.	

Four of the five reviewed youth records contained precautionary observations logs and required Assessment of Suicide Risk to return to standard supervision. Four youth records placed on precautions did have the logs filled out correctly, with the exception of one log did not have the designation of safe housing marked and one record did not have the shift supervisor's signature. Two youth interviewed confirmed the staff did observe them constantly while on 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.	

Three of the five reviewed pre-service training records and all five in-service training records had the required suicide prevention training, which include the two hours in the Department's learning management system, SkillPro, and the four hours on-site with the designated mental health clinician authority (DMHCA). Suicide prevention training is to train staff to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions. Suicide prevention training was provided to each staff as required. Mock drills were conducted quarterly on each shift and contained the needed requirements.

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

The program has a policy and procedures to 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 program. The written mental health crisis intervention services plan includes notification and alert system, means of referral (which includes, youth self-referral), communication, supervision (one-to-one, constant, and standard supervision), documentation, and a review process.

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

The program has a policy and procedures for crisis assessments. The program does have a policy and procedure for crisis assessments and related precautions, but no crisis assessments were available for observation during this review. The program has a written crisis intervention services plan which addresses those practices necessary to effectively handle youth in need of a mental status exam and crisis assessment and all required staff are appropriately training on crisis assessment.

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

The program has a written emergency mental health and substance abuse services plan. The written emergency mental health and substance abuse services plan includes immediate staff response, notification, communication, supervision, authorization to transport for emergency mental health services or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act), documentation, training, and a review process. The program did not have any youth who required emergency mental health or substance abuse services.

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

The program has a policy and procedures for 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. One youth was Baker Acted twice and returned to the program both times. Following a return to the program, the youth was placed on precautionary observation, constant supervision with one-on-one staffing until deemed safe for step down. After an administrative and clinical review of the Baker Acts, the program followed procedures and requested a treatment transfer to an intensive mental health program.

Standard 4: Health Services

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

The program has a medical doctor who serves as the designated health authority (DHA). The DHA is a licensed physician with a clear and active license. The DHA meets all requirements for independent and unsupervised practice in Florida. The DHA specializes in Family Practice, with experience in adolescent health. The program does not have a Collaborative Practice Protocol in place, as they do not employ an advanced nurse practitioner or a physician assistant. The DHA is on-site for at least one day each week, for a period of two hours. He is available twenty-four hours each day by telephone, if needed. The DHA was interviewed and indicated he covers the program and has not had to schedule coverage due to an absence. The program's registered nurse (RN) provided copies of sign-in and out logs for the previous six-months, to show consistency with the DHA visits to the program.

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

The program has facility operating procedures (FOP) for all health-related procedures and protocol utilized at the facility. Documentation shows the designated health authority (DHA), and nursing staff reviewed, signed, and dated a cover page for FOPs, treatment protocols, and other procedures. This is documented on an annual basis. There was documentation of the facility administrator signing and dating each FOPs. The DHA approves all treatment protocols or standing procedures. There are no blanket corporate policies, procedures, or protocols. The FOPs outline the program's healthcare services. There is documentation of all newly health care personnel receiving a comprehensive clinical orientation to Department's health care policies and procedures, given by a registered nurse or clinic manager.

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.	

Five youth healthcare records were reviewed and each contained a copy of the Authority for Evaluation and Treatment (AET). All were stamped "copy." All were filed in the healthcare records. There were copies of completed parental notifications maintained behind the AET in four of the five youth healthcare records. The remaining youth was eighteen years old and did not require parental notifications.

4.04 Parental Notification	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.	

Four of the five reviewed youth healthcare records documented the program keeps the parent/guardian informed of over-the-counter (OTC) medications beyond those covered by the

Authority for Evaluation and Treatment (AET), significant changes in the youth's condition, changes in the conditions and/or medicines prescribed to youth with chronic conditions and obtains consent when new medications and treatments are prescribed using the proper forms. Notification also includes off-site emergency care made by phone and in writing. There is documentation of a staff member witnessing all telephone call attempts and conversations. One of the records was not applicable, due to the youth being eighteen years of age.

4.05 Notification – Clinical Psychotropic Progress Note	Satisfactory Compliance
The program shall inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments.	

Five healthcare records were reviewed and three were applicable for youth who were on psychotropic medications. The three youth were started on psychotropic medication prior to admission to the program. Verbal and written notifications were documented, prior to the medication being continued, as required. The three written notifications were sent by mail. All verbal notification documented a witness was present when the notification was given. All written notifications included page three of the Department's Clinical Psychotropic Progress Note (CPPN), which included information about the psychotropic medication.

4.06 Immunizations	Satisfactory Compliance
All youth's immunization history and status shall be verified to meet state and department requirements, and subsequently provide necessary immunizations/vaccinations (with parent/guardian consent).	

Five youth healthcare records were reviewed. Each record documented a review of the youth's immunization history during admission and always within the thirty-day requirement. According to the registered nurse, the program uses Florida Shots or school records to review immunizations. All five youth immunizations were current. None of the youth required immunizations during the annual compliance review period.

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

All youth are screened upon admission for healthcare concerns which may need a referral for further assessment by healthcare staff. Five youth healthcare records were reviewed, and all contained a Facility Entry Physical Health Screening (FEPHS) form completed by a registered nurse during the youth's admission to the program.

4.08 Medical Alerts	Satisfactory Compliance
Staff shall be alerted of medical issues that may affect the security and safety of the youth in the facility.	

The program has a medical alert system in place. The medical alert list was updated by nursing staff each time a youth was admitted to the program, or when a youth's condition needed to be added or removed. Three staff were interviewed on how they are informed of youth's medication side effect. All stated during shift briefings, and staff meetings. Three of the selected youth were

classified with a medical grade three, four, or five. A review of the internal alert system revealed the alerts in the individual healthcare records matched the internal alert system.

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

The program has written policy and procedures concerning health education for you. According to the registered nurse, all youth receive a health care orientation upon admission to the program. Five youth healthcare records were reviewed, and each record documented the youth received an orientation to health care services on the day of admission to the program. The orientation packet covers all the required elements, to include sick call, what constitutes an emergency, notifying staff of side effects to medications and other issues, the right to refuse care, what to do in the event of sexual assault. The program has a contracted physician who serves as the designated health authority, and a contracted licensed psychiatrist who serves as the designated mental health clinical authority. Both are available by telephone twenty-four hours a day, and seven days a week.

4.10 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.	

There was documentation of the program notifying the designated health authority (DHA) each time a youth was admitted to the program, regardless of a youth's condition(s). This notification is recorded in the admission progress note. Five youth healthcare records were reviewed, and each record documented the DHA was notified of the youth's admission to the program.

4.11 Healthcare Admission Rescreening	Satisfactory Compliance
A Healthcare Admission Rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.	

The program has a policy and procedures requiring a new Facility Entry Physical Health Screening (FEPHS) form be completed every time the physical custody of the youth changes and they are subsequently returned or readmitted to the program. Five records were reviewed and three were applicable for requiring a new FEPHS form. Each youth had the form completed upon returning to the program. All of the screenings were completed by a registered nurse.

4.12 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 healthcare records were reviewed, and each contained the standard Department Health Related History (HRH) form used for all youth admitted to residential programs. Each of the healthcare records contained a new HRH form completed by a registered nurse on the day of admission. The designated health authority (DHA) documented a review of the HRH form, while completing the comprehensive physical assessment (CPA) in each record reviewed. Each HRH form was completed before the CPA.

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

Five youth healthcare records were reviewed, and each contained a standardized comprehensive physical assessment (CPA). The program completed a new CPA for each youth upon admission. All CPAs were completed by the designated health authority (DHA) within seven days of the youth's admission to the program. All of the CPAs were completed in accordance with Florida Administrative Code. Three of the youth were classified with a medical grade of five. The other two were classified as a medical grade one. All sections of the CPAs were completed. Each section of the CPA was marked with and "O" or an "X." There was documentation when a youth refuse any part of the exam, the clinician wrote "youth refused" or a similar term on the CPA. The Department's Problem List was updated, as required, for each record reviewed.

4.14 Female-Specific Screening/Examination	Non-Applicable
All adolescent girls shall receive gender-appropriate screenings, examinations, and tests to address their unique needs.	

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

4.15 Tuberculosis Screening	Satisfactory Compliance
All youth shall be screened for Tuberculosis, and accurate documentation of results shall be maintained by each facility.	

All five of the youth reviewed had a current Tuberculin Skin Test (TST) documented in youth's healthcare record. The Tier I tuberculosis screening section on the Facility Entrance Physical Health Screening (FEPHS) form was completed in each healthcare record. The results of the most recent TST and other testing methods were documented on the Infectious Communicable Disease (ICD) form in each healthcare record. The comprehensive physical assessment (CPA) also reflected the most recent testing for all five youth records reviewed. The program's written policy and procedures regarding tuberculosis screening is in compliance with the Centers for Disease Control and Prevention new 2006 recommendations and Occupational Safety and Health standards.

4.16 Sexually Transmitted Infection Screening	Satisfactory Compliance
The program shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).	

Five youth records were reviewed, and each contained a Sexually Transmitted Infection (STI) screening form completed by a registered nurse (RN) on the day of admission. All five of the screenings were reviewed by the designated health authority (DHA). All five youth received testing. The testing, screening results clinical evaluation, and diagnosis were documented on the Infectious and Communicable Diseases (ICD) form. The results were also filed in the lab section of the youth's healthcare record.

4.17 HIV Testing	Satisfactory Compliance
The program shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.	

Five youth individual healthcare records were reviewed for human immunodeficiency virus (HIV) testing. Each had evidence indicating the youth were offered counseling, testing, or treatment for HIV. Four of five youth agreed to the testing. One youth refused. Documented consent was obtained for the four youth. Testing was performed on the four applicable youth. The program provided documentation of the certifications for the HIV counselor providing testing and counseling for HIV. The program maintains a contract with Okaloosa Aids Support Information Services (OASIS) who provides all counseling, education, and testing for HIV for youth at the program. The test results were filed in a confidential manner consistent with Florida Statue 381.004. Documentation of pre and post-test counseling was also included in each of the four applicable records. The HIV results were sealed in a marked envelope which was noted 'confidential.' The program does not document the youths' HIV status within the internal alert system. All testing is completed on-site at the program. Three of the five interviewed youth reported they were able to request an HIV test if they choose. The other two youth stated they could not request an HIV. All youth sign a consent form stating the individuals to whom this information should be released.

4.18 Sick Call Process – Requests/Complaints	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.	

All youth are provided an orientation to the sick call process during the admission process. Each of the five records reviewed contained a signed acknowledgement form by the youth indicating they received this training. Sick call is provided twice a day at 8:00 a.m. and 5:00 p.m., seven days a week. None of the records documented the youth presented the same complaint three times in a two-week period. Four of the records indicated the youth requested sick calls. None of the youth complained of any severe pain with which staff was unfamiliar. All sick calls were conducted by medical staff. In the case of sick calls when the medical staff is not on-site, the direct care staff contact medical staff and fill out the correct paperwork. Once the nurse is back on-site, they review paperwork. Five youth were interviewed and reported they could be seen within twenty-four hours or less. Two youth stated they could see a nurse within one day.

4.19 Sick Call Process – Visits/Encounters	Satisfactory Compliance
The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters, as required by the Department.	

Five youth healthcare records were reviewed for this indicator. Each sick call request was addressed within twenty-four hours by a registered nurse (RN). The sick call request forms appropriately documented the youth's identifying vital signs, treatment rendered, education, and follow-up plans. The sick calls were documented in the subjective, objective, assessment, plan (SOAP) format on the proper form. All sick calls were documented on the individual youth's Sick Call Index and on the program's Sick Call Referral Log. There was documentation of each you signing, acknowledging they were seen by the nurse. Three interviewed staff reported sick call is completed by the nurse or doctor. The program's sick call process was observed during the annual compliance review. The sick call was performed by the registered nurse. A direct care

staff escorted the youth to the program's medical department and positioned themselves at the door of the medical room in order to maintain constant supervision of the youth. The youth provided verbal and written consent for the process to be observed for the purpose of this annual compliance review. The registered nurse identified themselves to the youth, and the youth was familiar with the medical staff. The youth was instructed to sign the sick call form and was seen in the medical room which was free from other youth. The nursing staff was observed contacting the youth's parent/guardian by telephone, with another nurse witnessing, to obtain permissions to administer over-the-counter medications. The nurse also was observed contacting the physician to advise of the youth's status. This information was documented in the youth's progress notes.

4.20 Restricted Housing	Satisfactory Compliance
All youth in Room Restriction/Controlled Observation s shall have timely access to medical care, as required by the Department.	

The program has a written policy and procedures for the use of controlled observation practices. Five youth individual healthcare records (IHCR) were reviewed and two were applicable for youth having an incident involving restricted housing; therefore, an additional record was reviewed. All three applicable records had documentation the youth had been placed in controlled observation for disruptive behaviors yet were still afforded medical services while in the room. The youth were questioned for any sick call or health complaints. The nursing staff made visits for each youth wile in controlled observation and documented this in the IHCRs. Two of the three youth were applicable for, and received, medications as ordered. Informal interviews were conducted with each of these youth during the annual compliance review. All three youth confirmed they received medical services during their time in controlled observation. Five in-service and five pre-service staff training records were reviewed for emergency procedures training. All ten records indicated the staff received the training, as required.

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

Five individual healthcare records were reviewed for episodic and first aid care. A review of the records found all youth required on-site first aid or episodic care. The care was administered by the nursing staff in three of the five records. The other two records documented care was administered by trained non-healthcare staff. The non-healthcare staff documented all necessary information in the youth's progress notes. The licensed healthcare staff documented the care utilizing standard narrative charting, and utilizing the subjective, objective, assessment, and plan (SOAP) format. A review of the program's episodic and emergency care procedures was completed. Emergency medical and dental care, are available twenty-four hours each day. The program maintains first aid kits in master control and provide kits for vehicles used to transport youth. The program also keeps an automated external defibrillator (AED) in the master control area. First aid kits and the AED are checked monthly by the nursing staff. Documentation of these checks were observed. First aid kits were fully stocked with approved contents. The program maintains an Episodic Care Log for documentation of all instances of first aid and emergency care.

4.22 Emergency Care	Satisfactory Compliance
The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.	

A review of the program's episodic and emergency care procedures was completed. The program maintains first aid kits in master control and provides kits for vehicles used to transport youth. The program also keeps an automated external defibrillator (AED) in the master control area. First aid kits and the AED are checked monthly by the nursing staff. Documentation of these checks were observed. First aid kits were fully stocked with approved contents. The AED procedures were located with the device. The registered nurse (RN) is responsible for checking the AED batteries and pads to ensure they are operable. Nursing staff was observed performing a check on the AED during the annual compliance review. A review of the device found the batteries have an expiration date of September 2022, and the expiration date for the pads was August 2021. The device was tested to ensure it was working. The program also conducts medical drills on a monthly basis. An interview with the clinical manager revealed the program has three shifts, and three registered nurses. The clinical manager develops the drill training calendar for the year. The clinical manager stated each RN is assigned a shift and is responsible for adherence to the drill calendar, while facilitating monthly drills for their assigned shift. A review of the drill documentation for mock emergency drills included evidence of cardiopulmonary resuscitation (CPR), first aid, and AED demonstration at least quarterly for each shift. A review of all drill documentation found no exceptions for any shift. Drills were maintained in a drill log binder, along with a log for inventory and inspection of first aid kits, emergency sharps, the bloodborne pathogen kit, and the monthly checks of the AED. The program has the number for the Poison Information Center posted within the nurse's station, as well as master control. Five in-service and five pre-service staff training records were reviewed for emergency procedures training. All ten records indicated the staff received the training, as required. A review of the training material and sign-in sheets found the program's medical department trains staff in the use of the EpiPen and medication administration when staff are hired. Three interviewed staff were asked if they were personally allowed to call 9-1-1 if a youth has a medical emergency. All staff reported yes, but most of the time a nurse or supervisor is contacted by staff and makes the call.

4.23 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 healthcare records were reviewed, of which one was applicable for off-site care. Two additional records were reviewed. Each of the three applicable youth had at least one incident which required off-site care. There was documentation indicating the youth's parents/guardians were notified of the off-site care. A summary of off-site care form was completed by the provider and/or discharge paperwork was attached to the summary. Each instance was reviewed and signed by the designated health authority (DHA). One of the youth required a follow-up appointment. There was documentation of the youth receiving appropriate, timely follow-up care as needed.

4.24 Chronic Illness/Periodic Evaluations	Satisfactory Compliance
The facility shall ensure youth who have chronic illnesses receive regularly scheduled evaluations and necessary follow-up.	

A review of five youth healthcare records was conducted and none were found applicable for youth with a chronic condition. Additional records were requested, and the program did not have any applicable records. An interview with the facility administrator revealed the program has morning management meetings in which the nursing staff attend and provide important updates regarding any medical issues pertaining to youth in the program. There is a program policy and procedures on how to handle youth with chronic illness with periodic evaluations.

4.25 Medication Management – Verification	Satisfactory Compliance
A youth's medication regimen shall be ascertained upon admission to the facility.	

The program has a policy and procedures in place concerning verification of medication. Five youth health care records were reviewed and three of the youth were found to have entered the program on prescribed medication. There was documentation of each youth's medication being verified prior to being accepted into the program in the youth healthcare record. A review of the Facility Entry Physical Health Screening form and progress notes for each youth revealed the youth were admitted with medications and verification was conducted. There was documentation in the progress notes of the designated mental health authority and parent/guardian being notified to resume the specified medications.

4.26 Medication Management – Orders/Prescriptions	Satisfactory Compliance
All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.	

Three of the five youth healthcare records were reviewed were applicable for prescribed medications. All of the medications had a current and valid order, pursuant to a current prescription. There was a medication order by the designated health authority (DHA) or psychiatrist for each medication prescribed, which included orders for over-the-counter (OTC) medications. The orders were clearly written and easily understood. One of the youth received OTC medications which were not on the Authorization to Evaluate and Treatment (AET) and they were administered in accordance with approved protocols or according to the practitioner's order. Each youth's progress notes and the DHA orders were reviewed to verify the youth's medication regimen.

4.27 Medication Management – Storage	Satisfactory Compliance
All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.	

The program has a policy and procedures concerning medication storage and disposal of medication. A tour of the clinic found all medications were located in a separate secure area inaccessible to youth. The medication cart was found to be clean and organized. All controlled medications were stored behind two locks in the medication cart. The clinic has a secured refrigerator which is used for medication only. Syringes and sharps were found to be secure. The program has a process in place concerning the disposal and destruction of expired and

discontinued medications. The medical staff will place these medication in to a solution called RX Destroyer. Once the container is full, it is picked up by SteriCycle, who has a contractual agreement with the program to pick up and dispose of these medications. The registered nurse provided examples of the disposal log and receipts of this service.

4.28 Medication Management – Medication and Sharps Inventory	Satisfactory Compliance
All medications and sharps shall be inventoried as per department requirements.	

There was documentation indicating all over-the-counter(OTC) medications were inventoried at least weekly, with no noted discrepancies. Syringes and sharps are counted whenever used using a perpetual inventory. The working and stock supply of syringes and sharps were counted weekly. A count of three randomly selected sharps were observed and the count matched the ending inventory numbers. A count of three randomly selected youth medications and OTC medications were conducted, and the counts matched.

4.29 Medication Management – Controlled Medications	Satisfactory Compliance
All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.	

The program has a written policy and procedures concerning pharmaceuticals, which details the inventories of medications at the program and articulates the procedures for medication management, to include controlled medications. The policy outlines the shift-to-shift procedure for inventory of these and all medications. Shift-to-shift counts were observed documented for the scope of the annual compliance review for all controlled substances. An inventory of three randomly selected controlled medications was completed during the annual compliance review. A nurse completed the inventory, and all medication counts matched the ending inventory numbers. Controlled medications were observed stored in a cart within the secure medical room. The medications were kept behind two locks within the cart. The youth do not have access to this area. A registered nurse (RN), who also serves as the clinical manager, trains the supervisory level, non-healthcare staff in the delivery and oversight of medication in the event medication needed to be delivered, but nursing staff is not on-site.

4.30 Medication Management – Medication Administration Record	Satisfactory Compliance
The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.	

The program uses the Department's Medication Administration Record (MAR). There is a MAR completed for each youth for each month. The MARs included administration of as needed medications, over-the-counter (OTC) orders, and all prescription medications. Each MAR documented all required information, to include each youth's name, Department identification number, youth allergies, medical grade, medication precautions, and start and stop dates. A picture of each youth was included in the binder next to their MAR. The MARs reflected youth received their medications, as prescribed/ordered. Medication side effects are monitored by the nurses daily. A review of three MARs of the youth reviewed currently taking medication found refusal of medications clearly documented with the letter "R." There was no documentation of any youth missing psychotropic medications. There was documentation of the staff administering the medications, initialing on each date the medication was given to the youth. A

review of the Facility Entry Physical Health Screening (FEPHS) forms found each of the three selected youth were admitted with medication. A review of the youth progress notes and/or the Authority for Evaluation and Treatment (AET) order section was conducted and found the youth medication was continued after admission.

4.31 Medication Management – Medication Administration by Licensed Staff	Satisfactory Compliance
Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.	

The program has a written policy and procedures for medication administration. A review of five individual healthcare records found none of the youth required parenteral medication. Observations of the medication administration process was observed during the annual compliance review. The working space for the registered nurse was clean and well organized. The nurse was observed to have control of the medication cart at all times. A direct care staff was observed directly supervising the youth during the medication administration process. The process was structured and well organized. The youth approached the cart and stated their name, date of birth, and confirmed their medication. The Five Rights of Medication Administration were verified for the youth. The Medication Administration Record (MAR), allergies, and alert status for the youth was verified by the registered nurse (RN) facilitating the process. The nursing staff documents weekly side-effect monitoring within the MAR. The direct care staff and nurse observe the youth taking the medication. The youth was instructed to open their mouth after they took the medication and turn their head down and to the side to cough. No refusals of medication were observed during this process. Five youth were interviewed concerning medication. Three of five youth stated the nurse gives medication. The remaining two youth stated they do not receive medication.

4.32 Medication Management – Medication Provided by Non-Licensed Staff	Satisfactory Compliance
Trained, non-health care staff may assist youth with self-administration of oral prescription medications or over-the-counter medications, only when licensed nurses are not available on site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.	

According to the program's policy, trained non-healthcare staff only assist youth with self-administration of oral, topical, or inhaled prescribed medication, and only what is authorized on the Authority of Evaluation and Treatment (AET) when the nursing staff is not on-site. The nursing staff delegate the delivery, supervision, and oversight of youth during self-administration of medications to trained staff. A list of trained staff was reviewed. The program had only one youth who was applicable for having medications provided by a non-licensed staff. A review of this record found both the youth and staff initialed the Medication Administration Record (MAR). The Five Rights of Medication Administration were verified and documented when medication was administered. Staff are required to observe the youth to ensure the medication is swallowed. A review of MARs showed non-licensed staff documented assisting youth with self-administration of oral prescription medications. Youth and staff both signed or initialed MAR. Five youth were interviewed concerning medication. Three of five youth stated the nurse gives medication. The remaining two youth stated they do not receive medication. All three staff interviewed reported the nurse primarily administers all medication to youth. Two staff also reported in the event the nurse is not on duty, a trained staff can administer the medication.

4.33 Medication Management – Psychotropic Medication Monitoring	Satisfactory Compliance
The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths' safety, as required by the Department.	

Five youth healthcare records were reviewed for monitoring of psychotropic medications. Three of the youth were applicable. One of the three youth received an initial diagnostic psychiatric evaluation within fourteen days of admission to determine if the youth needed those services. One youth was a day late due to the psychiatrist rescheduling their visit. The other youth was late due to Hurricane Michael. Both instances were documented in the youth's progress notes. The psychiatric evaluations were recorded on the Department's form with medication information documented on page three of the Department's Clinical Psychotropic Progress Note (CPPN). The evaluations addressed all required all elements, to include diagnosis, prescribed medications, and target symptoms and side effects of each medication. Medication monitoring was completed by the psychiatrist at least every thirty days. There was documentation of the psychiatrist and nursing staff monitoring for Tardive Dyskinesia on a monthly basis for youth prescribed antipsychotic medications. The program has no standing orders, pro re nata (PRN) orders, or emergency treatment orders for psychotropic medications.

4.34 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The facility 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 program has infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, as per Occupational Safety Health Administration federal regulations and the Centers for Disease Control and Prevention guidelines. The infection control procedures included all of the required information. The program reported having two incidents where youth had tested positive for chlamydia upon admission, and the progress notes for both of these youth records found notification was made by the medical staff to the local county health department.

4.35 Infection Control – Education	Satisfactory Compliance
The facility's comprehensive Infection Control education plan shall include pre-service and in-service training for all staff, and youth infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines.	

The program's comprehensive infection control education plan includes pre-service and in-service training for all staff. The youth's infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines, is offered to all youth. There is documentation in each of the five youth healthcare records reviewed of each youth receiving infection control training on the following: hand-washing techniques, standard precautions, prevention/transmission of communicable diseases, vaccinations and CDC guidelines for infection control. A review of staff training records revealed all five pre-service staff received infection control training and four of the five in-service staff completed their infection control.

4.36 Infection Control – Exposure Control Plan	Satisfactory Compliance
The facility's exposure control plan shall meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department.	

The program's exposure control plan was written in accordance with the Occupational Safety Health Administration standards OSHA (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department. The program has a site-specific blood-borne pathogen exposure control and infection control plan. The plan is available to all staff. The plan was signed by the facility administrator and designated health authority (DHA). The plan outlines risk assessment, methods of compliance, and processes for needle stick post-exposure evaluation. There were three or more cases of reportable infectious diseases needing to be reported to the local county health department and/or Centers for Disease Control and Prevention (CDC). There were no instances involving the quarantining or hospitalization of at least ten of the youth or staff. The facility administrator's interview revealed the program's exposure control plan is located in master control and nursing clinic.

4.37 Prenatal Care – Physical Care of Pregnant Youth	Non-Applicable
The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth shall be provided additional testing and services as recommended.	

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

4.38 Prenatal and Neonatal Care – Nutrition, Education of Youth, and Lactation	Non-Applicable
The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent shall receive prenatal, post-partum, and parenting education including topics directly related to health care issues and medical risk for pregnant adolescents. *The program provides education to pregnant and postpartum girls about infant care and lactation.*	

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

4.39 Prenatal and Neonatal Staff Education	Non-Applicable
All non-healthcare staff involved in the supervision or treatment of pregnant youth and their infants must receive appropriate education.	

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.	

Youth supervision was observed each day during the annual compliance review. The program's staff ratio is one staff to eight youth during the day and one staff to twelve youth during the night time hours. The program's youth care workers are responsible for active supervision of the youth, which they describe as the youth being within sight and sound, knowing their whereabouts at all times, and observing youth behavior. The daily schedule is posted in the living unit and consisted of a full schedule of activities planned. Staff were observed through video surveillance on six different occasions observing youth sleeping in their rooms.
When a staff was asked what the procedures are when they can't reconcile count, he replied, movement is stopped, and the facility is searched until the youth is found. If the youth is not found, escape procedures are implemented and law enforcement, facility administrator, assistant facility administrator, and the Central Communications Center (CCC) is notified. Each day when randomly asked, program staff were able to account for all youth under their supervision, as well as youth to staff ratio was in compliance during all the observations.

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) employed at the program.*	

The program has a policy and procedures in place for the behavior management system (BMS). A meeting was held with the program and education department for the development, implementation, and on-going maintenance of the BMS. There is a cooperative agreement between education and the program related to the BMS. The BMS is present in both, the staff and youth handbooks. A review of five youth records verified all five youth were given a copy of the youth's handbook at orientation by a signed receipt. The youth handbooks also include what entails positive and negative consequences for behaviors. There were observations of the BMS posted on the unit. There has been no change in the BMS since the last annual compliance review.

Three staff were interviewed and asked to explain BMS. Staff describe the BMS as a point or level system with rewards to consequences given at a four to one ratio. All three staff had a clear understanding of the BMS and how the system works. When those staff were asked what type of rewards the program provides as part of the BMS, they responded with off-campus outings, nightly incentives, Gotchas, video games, award ceremonies, and Big Friday where the youth can have special foods. When the staff were asked if things may be taken away from the youth as a consequence, two staff replied with television, video games, and iPod. The third staff

replied no. Five youth were interviewed and asked to explain the difference between each level and how you move from level to level. Four of the five of the youth had a good understanding of each level in the program and how to move up, whereas the fifth youth admitted that he was in trouble, so struggled to move up at this time. These same five youth were interviewed and asked about the punishers/consequences used in the program, as well as the rewards. For consequences, all five youth discussed early bed time, losing points, not being able to attend outings, and privilege restrictions. As for rewards, the five youth stated canteen, off-campus outings, gotchas, special foods and awards, and board games. The facility administrator was asked what behavior management system is used in the program. He replied with, “there are six levels at CYA” and explained the six levels in detail.

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

The program has a policy and procedures in place where staff are provided feedback regarding their implementation of the behavior management system (BMS). Part of the job description for a youth care specialist I at the program states he/she is to “provide a safe, secure environment through the use of group counseling techniques, individual relationships, “positive discipline” techniques, and the use of crisis intervention and de-escalation techniques as needed.” The program conducts discipline review court twice a week, which allows the staff an opportunity to explain to the youth the reason for any sanction imposed, gives the youth an opportunity to explain his behavior, and for both to discuss the behavior’s impact on others and alternative acceptable behavior. Five in-service and five pre-service staff training records were reviewed, and all ten records indicated staff received training for the BMS. Three staff were asked how youth are informed of the consequences and are they able to explain their behavior. All three staff stated that youth are able to explain their behavior with the unit manager, case manager, and supervisor or staff and one staff also added the youth can fill out a request to speak form to talk about the consequences. When asked how supervisors provide feedback to staff regarding the implementation of the BMS, all three staff stated, during training, one-on-one sessions, shift debriefings, and that staff sometimes all come together as a whole to discuss the best thing for each situation. Five youth were interviewed and asked if youth are ever allowed to punish other youth. Four of the five said no. The youth were also asked if staff are consistent in the use of rewards and all five said that staff treat the youth the same way, but one added that he feels every staff has their favorite kid, but they are mostly fair. The five youth were interviewed and asked to rate the BMS. Two youth replied with very good, two youth with good, and one youth said fair.

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

The program has thirty-two cameras, with twenty-seven of them operational. According to the facility administrator, the program's Digital Video Recorder (DVR) system can store video recordings up to thirty days. A sample of six evening/night shifts were observed through the DVR system for ten-minute checks and compared to the written ten-minute check log. Five of the six samples verified all checks were conducted in real-time, with staff initials, and in approximately ten-minute intervals. The remaining sample included a check completed at 9:10 p.m. and the next completed at 9:47 p.m.; however, the checks were not initialed by staff. Three staff were interviewed and asked how often room checks are conducted if a youth is placed in his room for sleeping or non-punishment reasons. All three replied with ten minutes, but one added that it can be done prior to 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 practicable 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 only has one log book located in master control. According to the log book, master control staff will enter count at the beginning of each shift. Master control staff initiates count every hour and documents the count in the log book. Observation in the unit, as well as in master control, found counts were conducted anytime there was movement with the youth, including outdoor activity, as well as every hour. After reviewing the log book, it was determined the total daily census count, head counts, youth movements, new admissions, releases, transfers, and youth who were temporarily away from the program were documented. Three staff were interviewed and asked how and when are youth counts are conducted and what happens when there is a discrepancy, including emergency counts. All three responded counts are conducted every hour. Two staff added non-scheduled counts or later at night counts, can be conducted every thirty minutes. If there is a discrepancy, one staff stated the youth are placed into their rooms, the second staff stated the youth line up against the wall, the third staff said they hold the youth and a re-count is completed until count is cleared. If necessary, a search would be conducted.

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

Several log books were reviewed within the six months of the annual compliance review period. All log books were bound with numbered pages, no pages were missing, and were not falling apart. All entries were made in ink and any errors were struck through with a single line and dated and initialed by the staff who corrected the error. No log books were removed. All entries included the date and time of the event, the name of the staff and youth involved, a brief description of the event, and the names and signatures of the staff making the entries. The program only has one log book located in master control. The log book has documentation of emergency situations, incidents, special instructions for supervision and monitoring of youth, population counts at the beginning and end of each shift, any other population counts conducted, and perimeter or other security checks conducted. Transports away from the facility, including the names of the staff, youth, and destinations were logged. Requests by law enforcement to access youth, removal of any youth from mainstream population, admissions and releases, information relating to escapes or attempted escapes, and any incident reported to the Florida Abuse Hotline and/or the Central Communications Center were logged in the facility log book. At shift change, the on-coming staff must initial and date the shift debriefing report, acknowledging they read the contents, as well as the shift supervisor must verbally brief staff of any situations which may have occurred. The shift report is also maintained in master control.

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

The program's policy and procedures for key control includes key assignment and usage including restrictions on usage, inventory and tracking of keys, secure storage of keys not in use, procedures addressing missing or lost keys, and reporting and replacement of damaged keys. Key inventory was reviewed and matched the actual keys in use. Observation was made of key distribution. Staff are to present their personal keys upon arrival at the program in exchange for their assigned facility keys, which they sign for on the key and radio control log. The personal keys are stored in the lock box in master control where the assigned facility keys go. For staff to receive their personal keys, they must return the facility keys. No personal keys are allowed in the program. According to master control staff, restricted keys consist of case managers, dietary, and therapist, and these keys are stored in a separate lock box in master control. In the lobby is a locked coded box which includes medical, assistant facility administrators, unit managers, and clinical director keys. Unrestricted keys are stored in a lock box in master control and consist of direct care staff, education, recreation yard, supervisors, and personal keys. All keys are securely stored. Property locker keys are stored on staff's

personal key rings or staff have a combination lock on their locker. The program uses the key and radio control log for daily training and reconciliation of keys. Damaged keys are logged in the log book, a Tool and Key Issue form is completed, and maintenance will replace. The program does have a policy in place for addressing missing or lost keys, but the program has not had any lost or missing keys within the last six months. Three staff were randomly asked if they had their personal keys and all three replied no. Three staff were interviewed and asked about the program's key control process including how keys are assigned, process for missing or lost keys, damaged keys, restricted keys, etc. All three staff replied the daily tracking of keys is completed through the key log, program keys are assigned to staff, and there is an inventory of keys. Two staff stated staff keys are given to master control upon entry, personal keys are securely stored, youth do not have access to keys, facility and youth are searched for missing keys, and keys are replaced for damaged keys. One staff commented that the Central Communications Center (CCC) is called for a missing key, while the second staff stated that he did not know how missing or broken keys were handled, but knew that if a key is lost, within two hours the program calls the higher ups and all the locks would have to be changed.

5.08 Contraband Procedure	**Satisfactory Compliance**
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. 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 youth.* *The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the facility administrator or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement.*	

The program has a policy and procedures in place regarding contraband, which includes approved and prohibited items, aligning with the Department's guidelines. The program's policy and procedures address searches of the physical plant, facility grounds, and youth; which are documented and logged. The program's policy addresses how to prevent contraband from entering the facility. Every individual who enters the facility is wanded by a staff member. There is also a metal detector which can be used but was not observed in use. The program's policy and procedures include if any staff is found in possession of contraband, they will be subject to disciplinary action up to and including dismissal. Law enforcement shall be contacted if any item found is considered illegal, as defined in Florida Statutes, and is turned over to the law enforcement agency. Other contraband found is confiscated, disposed, and all contraband is documented, as well as the disposition of the item. The program delineates items considered contraband, to include, but not limited to illegal items, sharps, escape paraphernalia, drugs, tobacco products, electric or vaporless cigarettes, non-program-Department -issued program equipment, and/or devices, unauthorized food or beverage, metals, cell phones, cash, keys, or any item not deemed unsafe or a threat to security. Youth are provided a copy of the youth handbook during orientation which has a list of items prohibited in the facility, as well as the

consequences if found with contraband. The youth handbook also addresses the youth's incoming and outgoing mail is searched.

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

Youth searches were observed before and after groups, education, obtaining brooms and mops, transport, and during admission. Visitation did not take place during this annual compliance review. When searches were conducted, youth were treated with dignity and respect. Searches were thoroughly conducted by the appropriate number of staff and by the same gender. Searches were conducted during routine movements. Three staff were interviewed and asked how youth searches were conducted. All three staff stated searches are done for every movement by a staff the same gender as the youth. The search is from shoulder to ankle. One staff added a full body visual search is conducted when a youth returns to the facility and after family day/visitation. Five youth were interviewed and asked when do searched occur. All five youth stated after outdoor activities, when items are missing, and after meals. Four of the five youth said when returning from off campus, after visitation, and whenever youth line up or anywhere youth exit and come back. One youth replied after work detail.

5.10 Vehicles and Maintenance	Satisfactory Compliance
All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment so they may be operated in a safe manner. *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 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 had one non-secure van (number five) on-site which is used for the transportation of youth. The second secure van (number one) was at the dealership during the annual compliance review week for repairs. Van number five was secured when approached. It had the appropriate number of seat belts, a seat belt cutter, a window punch, fire extinguisher, and a first aid kit stored in master control. A copy of van number five's annual inspection report was provided by maintenance, as well as monthly vehicle inspection sheets. The windshield of the van was cracked, but a claim was already filed with the insurance company to have it fixed. When two staff were asked if a youth can be attached to the van by any other means besides the seatbelt, both replied no.

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

An observation of two youth being picked up from Okaloosa Regional Juvenile Detention Center (ORJDC) for admission was observed during this annual compliance review. A male and female

staff were issued a radio for transport, since ORJDC is across the street. Otherwise, a cellular phone would have been checked out for the transport. Upon arrival at ORJDC, the youth were searched and placed in mechanical restraints for the transport. One youth was placed in the back row of the van, while the other youth was placed in the front row. The male staff stationed himself in the second row of the van in between the two youth and the female staff drove. All staff and youth wore their seatbelts during transportation. Youth were never left unsupervised in the van at any time. Staff advised youth are not permitted to drive program or staff vehicles. The program does have an approved drivers list, but the list was not provided at the time of the transport. It was later discovered the two staff conducting the transportation were not on the approved drivers list as of January 31, 2019. The program was contacted and provided a copy of the driver's licenses of the two observed staff. The van used for transport does not have a safety screen separating the front seats from the rear or passenger's seats, and the rear doors can be opened from the inside. Three staff were interviewed and asked what type of communication devices staff are provided with during transports. One staff replied cell phone, while the second staff believes master control has a cell phone, if not they are allowed to use their personal phone for work purposes only. That staff also added that they have a radio. The third staff replied with a transport phone or an authorized personal phone if Global Positioning System (GPS) is needed. These same three staff were asked if staff are allowed to use personal vehicles to transport youth and all three said no.

5.12 Weekly Safety and Security Audits	**Satisfactory Compliance**
Appropriate minimum staff to youth staffing patterns shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.	

The program has a policy and procedures in place which includes who is responsible for conducting the weekly security audits and safety inspections. The policy includes the development and implementation of corrective action warranted due to a safety and security deficiencies, consists of an internal system to verify deficiencies are corrected, and a system to improve and maintain compliance. The program completes and submits their safety and security audit documents to the Safety and Security Specialist weekly, as verified with the Specialist. Weekly audits were reviewed and were found to be completed, as required. According to the facility administrator, there are no deficiencies in weekly safety and security audits.

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

The program has a policy and procedures in place which includes the issuance, inventory, and control of equipment and tools. All tools are marked for easy identification and are maintained securely within the maintenance office. An inventory of all tools is completed prior to and following any work activities. The program uses a system of tool management, where all tools are marked, and photos are taken of tools within toolboxes, along with the corresponding number of tools in each drawer. Any tool checked out is to be signed out, and the area where the tool was stored will be replaced with a red tag, which identifies the tool as being signed out. A monthly inventory of all tools is completed by the maintenance person. A daily inventory is conducted on the maintenance person's tool bag, which includes a sharp-edged, pointed tools. Machetes, bowie knives, and other long blade knives are prohibited in this program.

An inventory of kitchen tools was also conducted, and found all items were accounted for. Kitchen knives were kept separately in a secured cabinet on the wall utilizing a shadow board system. The dietary director stated all kitchen tools and utensils are inventoried at the beginning and end of each shift. Damaged tools are replaced and disposed of by completion of a Tool and Key Issue form. The damaged tool will be disposed of by maintenance and replaced if necessary.

The program also maintains a limited number of cleaning tools, such as a mops and brooms, within a secured closet located in the dayroom on the youth's module. The doors to these closets were observed to be secured. There is a 'Class B Sign In/Out Form' on the module when these items are being used. Three staff were interviewed and asked which tools youth are allowed to use. All three stated mops and brooms, two replied scrub brushes, and one with screwdriver. The staff stated that a screwdriver may be used if the youth is with the maintenance staff. One staff added that a youth must pass a risk assessment in order to be allowed to use a screwdriver or hammer to help out maintenance.

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

The program has a policy and procedures in place for issuing tools to youth and staff, including an assessment to determine a youth's risk to self and others. The program's procedures determine the established ratios, tool distribution and collection, and search during work projects. The program is to maintain the following ratios during activities involving tool use is one staff for every five youth, disciplinary work projects is one staff to three youth, and vocational training is one staff to five youth. Youth were observed mopping in the unit on two different occasions and both times, staff to youth ratio was followed and the youth were searched upon completion of the mopping. The program is completing risk assessments on youth who use tools. Five youth were interviewed about what tools they are allowed to use. All five replied mops and brooms, two stated scrub brushes, one added a dustpan, and one stated every night, someone cleans the unit and we clean our own rooms.

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

A review of the outside contractor on-site work project log sheet verifies where the contractor's tools are checked upon arrival and departure and if there are any missing tools upon their departure. Two different outside contractors were able to be observed during the annual compliance review. Both contractors completed the outside contractor on-site work project log, one contractor was escorted by maintenance since they were in the secure portion of the building, and the youth were not allowed near the work area. When the contractors were on-site, there was documentation either in the log book or in the shift debriefing report. If an outside contractor needs to bring a prohibited item on-site, the facility administrator is responsible for approval of that item.

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

The program has a policy and procedures in place to provide for the safety and security of the youth and staff at all times, including events of a disaster or emergency. The program has a current Continuity of Operations Plan (COOP) which requires the program to conduct fire drills monthly. Each shift at the program conducted a fire drill monthly, for a total of three fire drills a month. Safety, evacuation, and disaster drills are to be practiced quarterly. Documentation with the type, date and time, participants, brief scenario, and findings/recommendations was provided for all drills. The program did have to initiate the COOP for Hurricane Michael; however, there was not a drill log completed for the actual event. Fire evacuation routes and egress plans are posted throughout the facility.

The facility administrator was interviewed and asked how often and what type of drills are conducted. He responded by stating that fire and medical drills are conducted monthly and suicide and disaster drills are completed quarterly. Three staff were asked what drills they have participated in within the last twelve months. Three stated weather and fire, while two staff stated bomb threat, chemical spills, and flooding. One out of three staff replied major disturbance, hostage situation, terrorism, escape, and disaster drill. Five youth were asked if they have ever been instructed on what to do in case of a fire. All five stated yes. One youth said that fire drills are monthly, maybe three times a month, and they line up, go to an exit door, head count going out and coming in. The second youth stated that fire drills happen three or four times a month. He added that a youth was having a seizure during one or two of them, so they practiced what to do in case that happened. The third youth admitted that fire drills happen but did not remember how often. The fourth youth replied with every three weeks or every month, day and night. The fifth youth said there has been a couple since he has been there, day and night.

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.	

The program has a policy and procedure addressing the Continuity of Operations Plan (COOP). The COOP is readily available to staff and is located in master control, which is at the main entrance of the building, and in the facility administrator's office. The COOP is reviewed and updated annually with the last review taking place on April 3, 2018. The program's disaster plan and COOP are one combined plan which addresses alternative housing plans approved by the applicable Department's Regional Director/designee. The program provided documentation the COOP was submitted on April 11, 2018 to the Department for approval and signed. The provision of equipment and supplies required for continuous operation and services were observed. The program's COOP includes fire and fire prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth that may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provision for public protection. The facility

administrator was asked if the disaster/COOP was easily accessible and where is was located. He responded yes, it is available to staff at all times in the mater control room.

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

The program has a written policy and procedures which addresses flammable, poisonous, and toxic item control. These items were observed to be secured in the following areas: outside chemical storage shed, outside secured closet, in a secured cabinet inside the bathroom in the kitchen area, and in a cabinet inside master control. The program stores the flammable materials such as diesel, gas, or pesticides outside the program in a metal storage unit in the sally port. The program maintained an accurate inventory of all the chemicals, flammables, poisonous, and toxics located in each area. The only persons authorized to handle these items in the program is maintenance and the facility administrator. Safety Data Sheets (SDS) are kept within a binder in each storage unit area, as well as the emergency number for Okaloosa County Recycling and Hazardous Waste Disposal. The binder also included a copy of the program's operating procedure for flammable, poisonous, and toxic control items, as well as a copy of the chemical disposal protocol. A review of each item observed found the corresponding SDS. Only maintenance staff and the facility administrator have keys to have access to the chemical storage areas.

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 maintains strict control of flammable, poisonous, and toxic items and materials. Youth are not permitted to handle or clean up dangerous or hazardous chemicals. During the annual compliance review, no youth were observed near the areas where the flammable, poisonous, or toxic items are stored. Youth were observed during daily cleaning activities and none of the youth were observed handling chemicals. Five youth were interviewed and asked if they handle paint, bug spray, gas, rubbing alcohol, paint stripper, floor wax, bleach, laundry soap, and/or window or toilet cleaner. All five youth stated that they do not use any chemicals. One youth added one time he helped with floor waxing and that he cleans toilets, but staff spray the toilets and put the stuff on the floor. A second youth added we only get soap, the staff uses the cleaners for the mop water.

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

The program has a written policy and procedures which addresses flammable, poisonous, and toxic control, and the disposal of these items. The maintenance staff is the only individual authorized to dispose of these items. There was no documentation provided which indicated maintenance received training for disposing hazardous items and toxic materials. Maintenance staff stated he follows the Safety Data Sheets (SDS) sheets for disposal of these items. Kitchen grease is disposed of in a metal grease trap, which is located outside the secure area. All kitchen liquid waste, except grease, is disposed through the kitchen drains and it goes into the grease trap. Disposal of the grease trap is completed with a bio-hazardous waste contractor, Superior Septic, monthly. According to the maintenance staff, all corrosive and flammable items are disposed of through a hazardous waste container taken by Okaloosa County Recycling and Hazardous Waste Disposal. Hazardous waste is disposed of in accordance with the SDS and stored in a hazardous storage area. Liquid wastes, such as dirty mop water, are disposed of in plumbing drains. If there is a chemical spill, staff will notify master control of the location. The shift supervisor/master control directs the shutdown of all air handlers and ventilation systems and closes all windows and doors at the direction of the supervisor. Assistance from outside the program is contacted as necessary, consistent with emergency procedures. The facility administrator was interviewed and asked what the program's disposable practice for flammable, toxic, caustic, and poisonous items. He replied that the disposal of all hazardous chemicals is accomplished within the parameters of state, local, and federal laws. He said that the grease is thrown out in the grease trap located in the sally port and all used chemicals are able to be disposed through the drains located in the utility closet.

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

The program's activity schedule has a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth. The program's policy and procedures have staff work with the youth to plan activities to expose youth to a variety of recreation and leisure choices, exploration of interests, constructive use of leisure time, and social and cognitive skill development, as well as promoting creativity, teamwork, healthy competition, mental stimulation, and physical fitness. During recreation, the youth have many different options, basketball, pull-ups, walking, bible study, cards, dodgeball, and board games. Staff were observed encouraging youth to participate in different activities and to do the best they can at the activity the youth were participating. Any movement of youth to recreation was documented in the logbook. Three staff were interviewed and asked what type of recreation and leisure activities are provided to the youth and how long are these activities. All three staff replied with one hour of recreation time. One staff stated that they do recreation daily as long as the weather permits, while another staff said the youth will get longer than an hour on the weekends. Two staff mentioned that the youth have P.E. with school every day. Examples of activities are dodgeball, pushups, jumping jacks, gaming systems, watch television, play cards, dominos, basketball, and football. Five youth were interviewed and asked if physical activities and leisure activities are provided for a least one hour. All five replied yes. One youth said they go outside everyday unless it is raining. A second youth stated that it depends on how they act during the

day. He said they go out in the morning and afternoon. A third youth stated sometimes we do not go out at all. He said sometimes it will be days we do not go outside and that it is not because of the weather. Four of the five of the youth stated they play basketball, football, kickball, cards, build paper towers, board games, bingo, X-Box, and/or dodgeball.

The program has had a vacancy for the position of recreational therapist since October 22, 2018. The individual who filled the position previously did not meet the required credentials stated in the programs' contract, a bachelor's degree of science in recreation and sports management with a track in Recreational Therapy. His degree was a Master of Science in Psychology with an emphasis in General Psychology. The position is currently posted.

5.22 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	**Non-Applicable**
Programs choosing to participate in water-related activities shall develop and implement a water safety plan to ensure proper supervision and safety of the youth during water related activities. The plan shall also ensure staff are appropriately trained for each specific type of water activity. *Programs allowing youth to participate in water-related activities shall have a water safety plan addressing, at a minimum, safety issues, emergency procedures, and the rules to be followed during water-related activities, as follows:* • *Determination of the risk level for each participating youth, including whether or not the youth can swim, an assessment of swimming ability, and other factors to include age and maturity, special needs such as physical and mental health issues, and physical stature and conditioning;* • *Type of water, such as pool or open water;* • *Water conditions, such as clarity, turbulence, and bottom conditions;* • *Type of activity, such as swimming, boating, canoeing, rafting, snorkeling, scuba diving, and shoreline and offshore activities to include fishing from a bank or pier, fishing while wading, or picnicking close to a body of water.* • *Lifeguard-to-youth ratio and positioning of lifeguards;* • *Other staff supervision; and* • *Safety equipment needed for the activity, such as personal flotation devices when youth are in a boat, canoe, or raft, and availability of a lifeline during shoreline and offshore activities.* *Programs choosing to participate in water-related activities shall ensure staff are appropriately trained for each specific type of water activity.* *Programs choosing to participate in water-related activities shall assess each youth's aquatic ability prior to participation in water-related programming.*	

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

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

The program has a written policy and procedures concerning visitation and youth access to correspondence and telephone. The program hosts visitation for youth on the weekends.

Visitation hours are 1:00 p.m. until 4:00 p.m. Saturdays and Sundays. The program separates the secure and non-secure population for these days. Youth who are committed to the non-secure component may receive visitation on Saturdays, and the secure population will receive visitation Sundays. The program posts the visitation schedule in the front lobby. Each youth receives a youth handbook upon admission, which also details the visitation and communication process for youth. When attending the visitation days, family members are required to sign in on a separate visitor sign-in form. A review of this documentation was done for the scope of the annual compliance review to confirm consistency with the practice. The sign-in forms are maintained in a binder, which also includes the youth's approved visitor list, and photo copy of the visitor's identification card. The case manager compiles the youth's authorized telephone, mail, and visitation list. The case management supervisor was interviewed and stated youth are afforded one free telephone call home each week. They also receive two free letters each week. Youth may earn additional phone calls or letters through the program's behavior management system.

Five youth was asked if they are given the opportunity to communicate with family members by mail or telephone or at visitation. All five stated yes. One youth stated his parents/guardians come every Saturday, the other four youth communicate through phone or mail.

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

The program has a policy and procedures in place for controlled observation. The program's controlled observation rooms meet the required specifications of thirty-five unencumbered square feet, metal door with shatter-resistant window, vents not easily accessible, recessed light fixtures covered with shatter-resistant material, and no electrical outlets. Five records were reviewed and all five records indicated the date-in, date-out, and time-in on the controlled observation report. Four of the five records documented the time-out of the controlled observation room. According to policy and procedures, staff are to inspect the controlled observation room prior to and leaving a youth alone in the room, as well as documenting that search on the controlled observation report. None of the five youth records had documentation of room search on the controlled observation report. According to policy and procedures, staff of the same gender are to conduct a search of the youth in the presence of another staff prior to leaving the youth alone in the room, and document the search on the controlled observation report. None of the five youth records had documentation of a search. Two random video reviews of controlled observation were selected and reviewed. One search was verified and one was not during controlled observation. At the exit meeting, the facility administrator provided the shift debriefing form for two of the five records reviewed. Attached to the shift debriefing form is an information report which states when the youth was placed in the controlled observation room, "the room was searched prior to and directly after the youth occupied the room." This search was not observed on the video surveillance for both youth.

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

The program provided a total of thirty-one controlled observations within the last six months. Five records were reviewed. None of the five youth exhibited behaviors indicative of mental

health crisis or suicide. All five received authorization from a supervisor or above for placement in the controlled observation room. Two of the five of the youth were displaying active aggression toward others, violent behavior, physically out of control, and staff needed to quickly gain control and order for the program's safety and security. The third youth was only displaying active aggression toward others, while the fourth youth displayed active aggression toward others and violent behavior. The fifth youth displayed violent behavior, physically out of control, and staff needed to quickly gain control and order for the program's safety and security. All five youth were advised by staff the reason for placement in controlled observation and expected behavior for removal. Three of the five youth had the healthcare professional complete the health status checklist, whereas the other two did not. Only one youth was granted extension beyond two hours in the controlled observation room by the facility administrator, whereas the other four were removed under two hours. Five youth were interviewed and asked if they have been sent to their room for punishment reasons during shift change or a cool down period. Two youth stated yes, and the other three stated no. One youth added that if we fight or do something stupid, we go to controlled observation. The second youth said no because he has never done anything. The third youth stated he was just put in there, but the door was left open and he was told to go in there and cool down.

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

Five records were reviewed and all five had the first page of the controlled observation report completed and submitted to a supervisor. Three of the five of the youth records documented staff conducted safety checks at least every fifteen minutes and observed the youth's behavior. The fourth youth had checks completed outside the fifteen-minute interval on two occasions, one with a gap of five minutes, the second with a gap of ten minutes. The fifth youth did not have any checks completed between 12:30 p.m. and 1:00 p.m. and his release time was not documented. All five youth had the safety checks and observations documented on the controlled observation safety checks form and the facility administrator or designee gave written approval for the youth's release. The controlled observation report, health status checklist, and controlled observation safety checks forms are maintained in the controlled observation report binder for all five youth. The facility administrator or assistant approved the controlled observation report within fourteen days of the youth's release in all five records. Staff determined if an in-house alert was warranted or not when the youth was released from controlled observation for all five youth.

Program Name: Crestview Youth Academy-nonsecure
Provider Name: Youth Opportunity Investment, LLC
Location: Okaloosa County / Circuit 1
Review Date(s): February 12-15, 2019

MQI Program Code: 1441
Contract Number: 10210
Number of Beds: 24
Lead Reviewer Code: 127

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.06 Gang Identification: Prevention and Intervention Activities	1.10 Delinquency Interventions and Facilitator Training
2.17 Educational Access	5.24 Search and Inspection of Controlled Observation Room
5.21 Recreation and Leisure Activities	
5.26 Controlled Observation Safety Checks and Release Procedures	