STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Crestview Youth Academy - Nonsecure

Youth Opportunities Investments, LLC.
(Contract Provider)
449 Straightline Rd
Crestview, Florida 32539

Review Date(s): November 17-20, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Tara Frazier, Office of Accountability and Program Support, Lead Reviewer (Standard One)
Lauren Floyd, Office of Accountability and Program Support, Prioritization and Planning Unit (Standard Five)
Warren Garrison, Office of Accountability and Program Support, Regional Monitor (Standard Three)
Jessica Gibson, Office of Programming and Technical Assistance, Technical Assistance Specialist (Standard Two)
Craig Swain, Office of Accountability and Program Support, Regional Monitor (Interviews)
Juan Youman, Office of Accountability and Program Support, Regional Monitor (Standard Four)

Program Name: Crestview Youth Academy - Nonsecure
Provider Name: Youth Opportunity Investments, LLC.
Location: Okaloosa County / Circuit 1
Review Date(s): November 17-20, 2020

MQI Program Code: 1441
Contract Number: 10210
Number of Beds: 24
Lead Reviewer Code: 166

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

Overall Rating Summary

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Provision of an Abuse-Free Environment *	Satisfactory
1.04	Management Response to Allegations *	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	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

* 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).

Program Overview

The Crestview Youth Academy - Nonsecure 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. The program provides the following services: mental health overlay services (MHOS), substance abuse treatment overlay services (SAOS), and borderline developmental disability/developmental disability treatment services through evidence-based delinquency interventions and the Impact of Crime curricula which enhances restorative justice awareness for the youth. The facility is a dual program with Crestview Youth Academy – Secure, which is a substance abuse program under the same contract provider. Additional services provided to the youth consists of Life Skills Training (LST, Male Healthy Relationships (MHR), Impact of Crime (IOC), Seven Challenges, and Skillstreaming.

The program administration is comprised of a program director, assistant program director, clinical director who serves as the program's designated mental health clinician authority (DMHCA), and nursing staff. The program employs a contracted psychiatrist who provides services bi-weekly, four master's-level therapist, two licensed mental health counselors, and four case managers which one who is working as the transitional case manager. The program has three registered nurses and a contracted medical doctor who serves as the designated health authority. Medical services are offered seven days a week from 6:00 a.m. through 6:00 p.m. Saturday through Friday. All positions are shared with the Crestview Youth Academy - Secure program. Education services are provided through an agreement with the Okaloosa County School Board. Crestview Youth Academy is also a General Educational Development (GED) testing site. The teachers are employed through the school district and provide classes Monday through Friday, where the youth are also given the opportunity to earn a Safe Staff certification through the dietary supervisor. The non-secure side of the facility is separated by the cafeteria from the secure side of the facility. The program has seventy-one operating cameras providing coverage. At the time of the annual compliance review, the program had fourteen vacant positions; ten safety security specialists and four shift supervisors.

Strengths and Innovative Approaches

The youth in the program created a victim garden where they plant flowers and maintain the upkeep of the garden and assist in the washing of the program's company vans and staff vehicles.

The youth provides written poems and paintings on World Peace which are displayed at the local public library, created cards for patients at a local rehabilitation retirement center, and prepares care packages for the local homeless shelter.

Standard 1: Management Accountability

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

The program has written policy and procedures to ensure all newly hired staff and volunteers receive an initial background screening. Ten newly hired staff and two interns were reviewed for initial background screening. All ten newly hired staff and both interns had a background screening, criminal history report, and an exemption obtained prior to hire. Three of the ten staff had a break in service as indicated in the Staff Verification System (SVS). Each of the newly hired staff had the pre-employment assessment tool administered and received a passing score. The staff and both interns were added to the Clearinghouse employment roster. The program's Annual Affidavit of Compliance with Level 2 Screening Standards was completed and submitted to the Department's Background Screening Unit (BSU) on December 3, 2019 meeting the annual requirement.. The Department of Education provided a copy of their annual screening on November 13, 2019 meeting the annual requirement.

During the annual compliance review , the program director explained the hiring process, ,the Central Communications Center (CCC) reports, Protective Action Response (PAR) reports, criminal history report, and/or SVS module which are reviewed prior to the hiring of staff.

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

A review of the employee roster indicated there were no staff eligible for a five-year rescreening during the annual compliance review period. The program have policy and procedures in place addressing five-year rescreening.

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

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

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

The program has a written policy and procedures in place which promote an environment of physical, psychological, and emotional safety. All new staff receive a copy of the employee handbook which includes a code of conduct, as verified through the acknowledgement page. A copy of the program's abuse reporting policy was provided, which included each step outlined in the provision of an abuse-free environment. The program last completed the Trauma Responsive and Care Environment (TRACE) self-assessment on December 20, 2019.
The program reported zero incidents of physical, psychological, and/or emotional abuse since the last annual compliance review. On November 19, 2020, three youth confided information to a monitoring and quality regional monitor which resulted in a call to the Central Communications Center (CCC), Florida Abuse Hotline, and notification to law enforcement. Law enforcement and the Department of Children and Families (DCF) responded to the program the same day and according to the program director, both will close their cases as unfounded.

Five youth were interviewed and each stated they feel safe in the program and have never been denied from calling the Florida Abuse Hotline. All five youth stated staff are respectful when interacting with youth. One youth stated staff use profanity when talking to the youth. The youth explained staff cannot help using profanity. None of the five youth stated they have ever exchanged emails or social media information with staff. Five staff were interviewed on the process in how staff allow youth to report allegations of abuse to the Florida Abuse Hotline. All five staff replied youth are allowed to make the call and staff are to notify the program director and supervisors. None of the five staff reported ever seeing an employee deny a youth the right to call the Florida Abuse Hotline. One staff admitted seeing and hearing another staff member use profanity, threats, intimidation, or humiliation toward youth. This staff member added it was not directly at the youth.

The program director (PD) was interviewed on the actions taken if staff violated the program's code of conduct. The PD stated depending on the violation, disciplinary action including termination of employment. The PD explained the CCC and Florida Abuse Hotline reporting process by indicating to contact administration as soon as possible with the details of the incident. The PD s made aware of the incident. The determination on whether the incident is reportable based on administrative rule. The call will be placed within two hours of gaining knowledge of the incident. If the incident involves staff, the staff will be removed from youth contact until further notice. All documentation, reports, and other notification will take place. The PD ensures staff and youth are knowledgeable of the policy by having postings throughout the facility, reminding youth in townhouse meetings, and monthly all team meetings with program staff.

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 had no incidents of physical, psychological, and emotional abuse during this review period; therefore, this indicator rates as non-applicable.

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

The program had a total of nine Central Communications Center (CCC) reports in the previous six months. A sample of five CCC reports were reviewed. All five incidents were reported within the two-hour time frame and documented in the master control's logbook. The program only had three CCC reports the previous six months. The program director explained the increase in the CCC reports was due to the COVID-19 pandemic and an acute youth who was not adapting to the program, who was recently transferred. The reviewed reports supported this explanation.

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

The program had a total of ten Protective Action Response (PAR) reports in the previous six months. Five reports were reviewed and each were completed by all staff members involved by the end of the workday. All five reports were reviewed by a PAR certified instructor within seventy-two hours and placed in a centralized file within forty-eight hours of being signed by the administrator. All reports had a post-PAR interview conducted with each youth but the time was not documented on the report to determine if the interview was conducted within thirty minutes of the incident. The program director (PD) verified where all PAR reports were submitted by the fifteenth of each month to the Department. A copy of the approved PAR plan was provided. The

program had an increase in the number of PAR incidents since the last annual compliance review. The PD explained an acute youth was transferred to the program causing a disruption. This youth was not adapting to the program and was recently transferred to another program earlier in the month of November. The reports supported this explanation. The program's PAR rate during the annual compliance review period was 2.56, which is above the current statewide Residential PAR rate of 2.10.

The PD monitors all PAR reports at the program and discusses the reports with staff in the all team meetings, shift debriefings, and coaching sessions, if needed. The PD stated the treatment team makes all attempts to help the youth with tools to be compliant in the program and successful in their treatment.
Five staff were interviewed and questioned if they have ever utilized PAR. Four staff stated they have and explained how staff talk to youth, complete the report by the end of the day, and have the youth seen by medical, if necessary. The fifth staff responded never having to utilized PAR.

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

A sample of six pre-service training records were reviewed. Four staff completed the 120-hours of pre-service training within the required 180-days of hire. The remaining two staff are currently in the process of completing the pre-service training which the 180-days are due for completion on January 30, 2021 and February 6, 2021, respectively.

All six staff completed cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and right interactions (RI). One of the six staff did not pass the written exam of RI; therefore, the staff did not receive certification. The program director (PD) moved the staff into the master control position, having no contact with youth. All six staff completed training in child abuse reporting, Prison Rape Elimination Act (PREA), human trafficking, and active shooter training. Five of the six staff completed ethics including standards of conduct, a minimum of six hours of suicide prevention/intervention, and emergency procedures. The remaining staff is currently working on completing their hours in these areas.

Additional required contractual training includes restorative justice, stress management, grievance process, and post-traumatic stress disorder (PTSD). All six staff completed restorative justice and stress management. Five staff completed grievance process and PTSD. The remaining staff is currently working on completing their hours in these areas.

All training requirements were documented in the Department's Learning Management System (SkillPro) and provided by a qualified instructor to deliver the training. The program submitted a signed copy of the pre-service training list including the course names, descriptions, objectives, and training hours to the Department's Office of Staff Development and Training on January 19, 2019.

An interview with the program director confirmed unit managers, safety security specialists, and shift supervisors are considered direct care staff and are counted in the staff-to-youth ratio.

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

Five in-service training records were reviewed.. Each of the five staff completed more than above the minimum of twenty-four hours annual training. All five staff completed cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), ethics, and grievance process. Four staff completed right interactions (RI). The remaining staff held a dietary position in 2019 and moved to the master control position in 2020. This staff did complete and pass the RI training on August 14, 2020. Four staff completed a minimum of six hours of suicide prevention/intervention and the remaining staff completed four hours. Four staff completed human trafficking, and the fifth staff completed the training on July 26, 2018. According to the program's training plan, human trafficking is required ever two years. Three of the five staff completed active shooter training, which is not required. The program currently has one supervisor employed. The supervisor received ten hours of annual training in management, leadership, personal accountability, employee relations, and communication skills.

All training requirements were documented in the Department's Learning Management System (SkillPro) and provided by a qualified instructor to deliver the training. The program provided a signed copy of the in-service training list including the course names, descriptions, objectives, and training hours submitted to the Department's Office of Staff Development and Training on January 19, 2019. The program director (PD) maintains a copy of the annual in-service calendar in the program's office, which is updated as changes occur. An interview with the PD confirmed unit managers, safety security specialists, and shift supervisors are considered direct care staff and are counted in the staff-to-youth ratio.

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 states all youth in the program's care shall be treated fairly, respectfully without discrimination, and shall have their rights protected. This policy states all staff will receive training on the grievance process as part of the new hire training process. The policy includes the Informal, formal, and appeal phase including the steps of each phase as well as time frames. Assigned grievances will be reviewed and investigated within two days of assignment. The program's goal is to handle all grievances expeditiously and all efforts will be made to conclude the process within five working days.

The program had two grievances in the past twelve months which were resolved in the formal phase within the required time frame. The program maintains copies of grievances in a binder for the previous twelve months

Five youth were interviewed and reported grievances are placed throughout the facility and were aware of the three phases involved in the process. All five youth stated they are able to ask for assistance when completing a grievance form. Five staff were interviewed and able to explain the grievance process. All five staff knew where the forms are placed throughout the facility and were knowledgeable of grievance review process by the supervisor and program director (PD). Four staff was aware youth could request assistance in completing the grievance form. Three staff were knowledgeable of the three phases of the grievance process and the time frames associated with each phase.

An interview with the PD reflected their understanding of the grievance process. The program follows a four step process to include step one where the youth completes the grievance. In step two, the shift supervisor collects all grievances and meets with the youth regarding their concerns. In step three if the youth does not agree with the outcome, the youth can meet with the assistance program director (APD), and in step four. If the youth does not agree after meeting with the APD, the youth can meet with the PD.

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

Training records were reviewed for the program's two case managers in which both had the required level of education, training, and experience. A review of the program's contractual requirements was completed and the program is conducting all groups pursuant to the contract table. The groups include delinquency interventions for each youth through evidence-based practices, promising practices, or a practice with demonstrated effectiveness such as Life Skills Training (LST), Male Healthy Relationships (MHR), Impact of Crime (IOC), Seven, and Skillstreaming. A review of the sign-in sheets confirmed groups are being offered according to the program's schedule. The schedule does provide structured, planned programming, or activities at least 60% of the youth's awake hours.

Five youth's performance plans were reviewed and all five youth are involved in a delinquency intervention addressing an identified priority need, which is also addressed in the individualized performance plan. All five youth participate in MHR, Skillstreaming, and IOC.
Five youth confirmed they participate in groups at the program and have practiced new skills learned from these groups while at the program. The program director stated the therapists and case managers have the appropriate education and credentials to facilitate the applicable intervention groups at the program.

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

The program provides Life Skills Training (LST) and Male Healthy Relationships (MHR) to provide interventions or instruction on developing life and social skill competencies in the youth. These services address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. A review of the sign-in

sheets confirmed groups are being offered according to the program's schedule. The schedule does provide structured, planned programming, or activities at least 60% of the youth's awake hours. Five youth confirmed participating in groups at the program and have practiced new skills learned from these groups while at the program.

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 provides Impact of Crime (IOC) to enhance the youth's awareness of and empathy for, crime victims and survivors, and increase personal accountability for the youths' criminal actions. These activities are designed to assist youth to accept responsibility for harm they have caused by their past criminal actions and teach youth about the impact of crime on the victims, their families, and their communities. They also assist the youth by exposing the youth to the victims' perspectives through victim speakers and provide opportunities for youth to plan and participate in reparation activities intended to restore victims and communities. This class is offered twice a week. A review of the sign-in sheets was completed which confirmed group was being offered according to the program's schedule.

Five youth confirmed they participate in groups at the program and have practiced new skills learned from these groups while at the program. According to the program director (PD), the program has been limited this previous year with going into the community to participate in activities which would qualify in reparation activities due to the COVID-19 pandemic. The youth have created a victim garden where they plant flowers and maintain the upkeeping, assist in washing the program's company vans and staff vehicles, written poems and paintings about World Peace which are displayed at the local public library, created cards for patients at a local rehabilitation retirement center, and currently working on care packages for the local homeless shelter.

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

The program offers Male Healthy Relationships (MHR) curriculum twice a week by a master's-level therapist to the youth as a delinquency intervention and gender-specific treatment service. The curriculum includes Young Men's Work and Teen Relationships. The curriculum includes ways males are viewed within the community and how to break the cycle of violence and gender role stereotypes in order to successfully build relationships and reintegrate back into the community. During the curriculum, the youth receive male healthcare education. A review of the sign-in sheets confirmed group are offered according to the program's schedule.

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 in place which address internal alerts and Juvenile Justice Information System (JJIS) alerts. The program has an alert board in administration which contains all open victimization, medicines/psychotropic, suicide risk/mental health, allergies, gang, escape, out of placement, and activity restrictions alerts. The program director stated alerts are printed daily and reported medical alerts are updated in real time. If there is a change in medical, the nurse will send an email which will automatically be added to the alert board in administration. If applicable, the alert will be discussed during shift debriefings and in the morning management meetings, which medical attend. Dietary staff maintains a list of all youth who have allergies along with the youth's pictures.

Five youth records were reviewed for internal and JJIS alerts. All JJIS alerts were entered or removed by the appropriate staff and matched the internal alert log. Closed security alerts, which are displayed on the alert board in administration, were unable to be verified due to the alert board being in real time. Five staff reported they are notified of alerts through daily debriefings and the alert board.

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

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

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

The program has several formal processes to promote constructive input by youth. The program director (PD) believes in administration presence with the youth to help youth feel more

comfortable with staff and talking with staff about ideas to better their stay at the program. The program have “Request to Speak” forms, weekly town house meetings, bi-weekly youth advisory board and student council meeting, and monthly surveys. Five youth were interviewed and four stated they can speak to the staff if they want to provide input to the program. The remaining youth added they can provide input to the student council.

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

The program has an advisory board which meets quarterly. The program director (PD) indicated times may vary depending on the members’ schedule. The PD provided copies of advisory board meetings, sign-in sheets, and minutes for the previous year, as well as a list of the members. The last board meeting was scheduled on August 20, 2020; however, there were no advisory board members at the meeting. The PD stated invitations are mailed to board members and telephone calls are made to confirm with members; however, if a member is not available documentation is provided. On November 23, 2020, another quarterly meeting was conducted by telephone. A list of board members in attendance as well as the minutes was provided.

The program’s advisory board consists of members from law enforcement, judiciary community, other community partners, business partners, school board or district, faith community, LGBTQI community, and victim advocacy.

A telephone call was placed to one of the board members who assists with the high school high techs (HSHT). HSHT is a nationally recognized program which covers youth ages fourteen to twenty-two with a disability offering a wide variety of career opportunities with an emphasis on technology related and in demand careers. HSHT provides students the opportunity to develop their academic and leadership skills as well as build self-confidence and other job-related skills. The board member stated they enjoy participating on the advisory board and believes this program is beneficial for the youth. The board member witnessed youth at the meetings and speak of the highlights and progress they have accomplished while at the program. The board member stated being a part of the board helps in making connections to other agencies, finding mentors, and community worksites.

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 policy and procedures in place to address the effective channels of communication among program staff, corporate leadership, other agencies, stakeholders and departments, and between youth and staff. The program has an open-door policy to provide input and feedback pertaining to operation of the program. There is an employee morale committee which includes staff from all departments, excluding administration. This committee hosts staff dinners and activities.

The program has developed several initiatives for staff retention. The program recognizes an employee of the month who receives a monetary gift, as well as purchase Christmas gifts and raffle the gifts to all their staff. Administrative staff distribute poker chips to staff working above and beyond their job duties and responsibilities. The staff turn in the poker chips at the monthly

all team meetings to be eligible for various raffles and prizes. The program director (PD) has increased cookouts, potlucks, movies, bowling, and meals on management. The PD stated utilizing the PAR analysis report as positive incentives for staff and youth to continue to maintain low rates. Corporate utilize the Comprehensive Accountability Report (CAR) report to look at the recidivism rates. The program discuss the rate on youth completing services which occurred within twelve months of their release from the community or supervision.
The program has morning management meetings which include the PD, human resources, clinical director, medical, and assistant program director Monday through Friday, as well as daily debriefings. The program also hold all team meetings, shift supervisor meetings, employee morale meetings, Standardized Program Evaluation Protocol (SPEP), and corporate meeting monthly. The program completes monthly youth and parent/guardian surveys. The results of the surveys are included in a key performance indicators (KPI) report which is submitted to the corporate office. Once the surveys are reviewed, they are forwarded to the PD to share with staff during the all team meeting for corrective action, if necessary.

The program currently has ten safety security specialist (SSS) positions and four shift supervisor vacant positions. Five staff were interviewed on how often staff meetings are held and each stated daily or monthly. The staff were interviewed on what topics are discussed during the meetings. All five staff had appropriate responses such as alerts, drills, ratio, boundaries, new youth, and/or number of youths. Four of the five staff stated they are briefed on annual reports or survey results. All five staff rated the communication at the program as good to fair and they can provide input and feedback at any time into the program's operations.

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

The program has a written policy and procedures in place ensuring a system for evaluating staff. The policy states staff will receive an initial ninety-day evaluation followed by annual evaluations, usually during the months of July or August. The program provided samples of job descriptions along with the performance evaluations which matched the position. All key positions are being maintained in the program at this time.

Four of the five interviewed staff reported they receive an evaluation annually. Two stated monthly, one stated ninety days, and one stated three months. The program director confirmed staff receive a ninety-day evaluation, followed by annual evaluations.

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

The program has a written policy and procedures in place for providing youth with a variety of recreation and leisure activities. The program's activity schedule provides allotted times for the youth to participate in leisure, recreation therapy, inside recreation, and outside recreation time. All youth are encouraged to explore interests and engage in constructive use of leisure time. The youth at the program help recommend the activities they would like to participate in and add the activities to the schedule through the youth advisory board. The activities include football tournaments within the module, dodgeball, kickball, volleyball, art projects, chess, checkers, four corners, cornhole, board games, and video games. On family day, the maintenance staff brings certain farm animals to the program for the youth and their families to enjoy. During the week of

the annual review compliance, the youth were observed engaging in recreation activities. A random review of the program's logbook confirmed the youth are receiving the activities according to the program's activity schedule.

Due to budget cuts, the program was no longer able to retain the recreational therapist position, as of August 1, 2020. Currently the safety security specialists (SSS) are running all recreation and leisure activities. Five youth confirmed the program allows time for playing sports, working out, down time, and board games. Five staff reported the youth get a minimum of one hour of recreation daily including playing sports, video games, playing cards, dodgeball, cornhole, and video games.

Standard 2: Assessment and Performance Plan

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

Five youth case management records were reviewed for initial contacts to parent/guardians. Each of the five records contained documentation the program notified the parent/guardian by telephone within twenty-four hours of the youth's admission.
Five youth case management records were reviewed for initial written notification to the youth's parent/guardian in writing within forty-eight hours of admission to the program. Each record contained documentation the program notified the parent/guardian in writing within forty-eight hours of the youth's admission. Each of the five youth case management records contained evidence the court, juvenile probation officer, and post-residential counselor, if applicable, was notified in writing within five days of the youth's admission.

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

Five youth case management records were reviewed for orientation requirements to include but not limited to program rules, procedures, schedules, and services applicable to youth, to begin on day of admission. Documentation in the case management records confirmed the program provided all five youth an orientation on the day of admission. The orientation included services available, daily schedule, expectations and responsibilities of the youth, written behavioral management system within the youth handbook, availability of and access to medical, mental health, and substance abuse services, access to the Florida Abuse Hotline and the Central Communications Center, the zero tolerance policy regarding sexual misconduct, and how to report incidents or suspicions of sexual misconduct.

There was documentation the program provided information on special accommodations in writing to ensure information is provided about how to report sexual misconduct, is conveyed verbally to youth with limited reading skills or who are visually impaired, deaf, or otherwise disabled. Five youth case management records included documentation the youth were informed of the right to be free from sexual misconduct, rights to be free from retaliation for reporting such misconduct, and the agency's sexual misconduct response policies and procedures. The youths' orientation also included items considered contraband, illegally prohibited items, and possession of which may result in the youth being prosecuted. The program documented in all five youth case management records the youth were informed of the performance planning process involving the development of goals for each youth to achieve, dress code and hygiene practices, procedures on visitation, mail, and use of telephone, expectations for release from the program, included the youth's successful completion of individual performance plan goals, recommendation to the court for release based on the youth's performance in the program, the court's decision to release, community access, grievance procedures, emergency procedures including for fire drills and building evacuation, facility tour and general layout of the facility, focusing upon those areas not accessible to the

youth, assignment to a living unit, room, treatment team, and a staff advisor or youth group, if applicable, and medical topics as outlined in Chapter 63M-2.

A youth admission was observed during the week of the annual compliance review. The youth's admission and orientation included all the elements outlined in the program's policy. Five youth were interviewed and each indicated their orientations began within twenty-four hours of admission. The staff conducted an informal treatment team with the youth upon admission. The youth's parent/guardian was contacted by telephone and all members of treatment team communicated with the parent/guardian and the youth which included all requirements of the program's orientation process.

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

The program obtains written consent of youth eighteen years of age or older, unless the youth is incapacitated and has a court-appointed guardian, before providing or discussing with the parent/guardian any information related to the youth's physical or mental health screening, assessment or treatment. The program had two youth during the annual compliance review period who were eighteen years of age. Both youth had a written consent obtained before providing or discussing with the parent/guardian, Agency for Persons with Disabilities (APD), and the Department of Children and Families (DCF), if applicable information related to physical or mental health screening, assessment, or treatment.

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

The program utilizes a classification system in accordance with Florida Administrative Code, promoting safety and security, 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. Five youth case management records were reviewed and contained documentation of an initial classification form which was completed the day of admission and included physical characteristics, age, maturity level, identified special needs, including medical, mental health development, or intellectual and physical disabilities, history of violence, and gang affiliation. Each youth's case management record had documentation of a new Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) being completed for each of the five youth and entered into the Juvenile Justice Information System (JJIS) prior to a youth's room assignment. All five youth case management records contained documentation of a youth's criminal behavior, sexual

aggression or vulnerability to victimization, youth's perception of vulnerability, youth's history of potential or verified human trafficking, suicide risk, medical risk, escape risk, security risk, review of JJIS alert list for any issues affecting classification, youth classified for purposes of assigning to a living area, sleeping room, and youth group, or staff advisor, medical, mental health, substance abuse, security risk factors, and/or special needs identified during or subsequent to the classification process are immediately entered into the program's internal alert system and JJIS. All five youth case management records included documentation the youth were classified according to the classification procedures and placed accordingly.

The 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 with potential to be used as weapons or means of escape, or participation in any off-campus activity. All youth admitted to residential commitment programs shall be screened for vulnerability to victimization and sexually aggressive behavior prior to room assignment. Room assignments by staff shall ensure a youth's potential for victimization or predatory risk has been reviewed. The screening shall be completed in the Juvenile Justice Information System (JJIS). Five youth case management records included documentation all five youth was reclassified to include an increase in the youth's privileges or freedom of movement. Four youth had reclassifications for participation in work projects, or other activities involving tools or instruments which may be used as potential weapons or means of escape, and participation in off-campus activities. One youth was not reclassified due to behaviors while in the program and was not allowed participation in work projects, or other activities involving tools or instruments with potential to be used as weapons or means of escape, and participation in off-campus activities and documentation was located in the youth's case management record.

The program director was interviewed to determine how factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning a youth to a living unit and/or sleeping room. The interview included an explanation of the youth are assessed using a VSAB upon their admission to the program and again with any major incidents which cause suspicion a youth may be vulnerable to victimization from others or sexual aggression. If a youth has several indications such as young age, small size, or disability then they would be placed in a room at the front of the hall for closer monitoring and possibly shower separately.

The program's policy/procedures were reviewed and clearly outlined the classification process and included a classification system promotes safety and security, as well as effective delivery of treatment services based on determination of each youth's individual needs and risk factors, which addresses, at a minimum, items outlined in Administrative Rule. The policy also addressed when reassessments are warranted which are based upon changes in the youth's supervision status, new/updated alerts, relevant information available to the treatment team, and/or behavioral concerns.

The program's internal alert system was reviewed and confirmed the program has continually updated the internal alert system, which is easily accessible to program staff and keeps them alerted about youth who are security or safety risks included escape risks, suicide or other mental health risks, medical risks, sexual predator risks, and other assaultive or violent behavior risks.

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

The program gathers and maintains information on gangs and shares this information with law enforcement. The program maintains a binder which contains all contacts with required authorities regarding identified or suspected gang members in the program. Three of the five youth case management records reviewed were identified as gang members. All three case management records included documentation of when the youth was identified as a gang member, local law enforcement notification, the youth's residential home county law enforcement notification, and gang alerts were added in the Juvenile Justice Information System (JJIS). Five youth case management records included documentation the youth's gang status was shared with the education provider, juvenile probation officer, and post-residential counselor, if applicable.

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

A residential commitment program shall implement gang prevention and intervention strategies. The residential commitment program shall provide intervention strategies when youth or identified as being a criminal street gang member, are affiliated with any criminal street gang, or are at high risk of gang involvement.

Three of the five youth case management records reviewed were identified as a gang member or affiliated gang member. Three youth case management records contained documentation the youth participate in gang prevention and intervention strategies. Three youth case management records included documentation the youth's performance plan included relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program. The program conducts the Impact of Crime groups ongoing. Gang intervention and prevention meetings are held monthly. The program's policy and procedures were reviewed and included the youth have the opportunity, if they desire, to develop a plan to dis-affiliate with a criminal street gang.

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

Five youth case management records were reviewed for completion of the Residential Assessment for Youth (RAY) within thirty days of admission. Five youth case management records were reviewed and contained documentation all five initial RAY assessments were

completed within the first thirty days of each youth's admission to the program. The initial RAY assessment was maintained in the Juvenile Justice Information System (JJIS).
Three youth required an updated RAY assessment. All three records reviewed were completed within ninety days of the initial RAY assessment. Three youth case management records contained documentation reassessments were completed when deemed necessary, by the intervention and treatment team to effectively manage the youth's case. All reassessments were maintained in the youth's official case

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

The program ensures a Youth Needs Assessment Summary (YNAS) was completed within thirty days of the youth's admission to the program. All five YNAS reports were documented within the Juvenile Justice Information System (JJIS).

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

The program maintains a written policy and procedures to ensure the intervention and treatment 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. A review of five youth case management records documented the initial performance plans were developed within thirty days of each youth's admission. Five individual performance plans were developed after the initial assessment was completed.

All five youth case management records documented the intervention and treatment team leader, youth, administrative representative, treatment staff, and all parties who had significant responsibility in goal completion were present during the development of the individualized performance plan and had the opportunity to sign.. Four of the five youth case management records contained documentation the education staff was present during the development of the individualized performance plan. There was documentation within the record the education staff was out due to COVID-19 pandemic; however, education input was provided for the individualized performance plan development.
Two of the five youth were involved with the Department of Children and Families (DCF) which both case management records included documentation the DCF casework was involved in the development of the individualized case plan. Five youth case management records included

information the signature sheet from the individualized performance plan was sent to the parent/guardian and filed in the case management record.

Five youth individualized performance plans were reviewed and included individualized goals based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process, the top three identified criminogenic needs, specific delinquency interventions with measurable outcomes decreasing criminogenic risk factors and promote strength, skills, and supports reducing the likelihood of the youth reoffending target court-ordered sanctions reasonably initiated or completed while in the program, transition activities targeted for the last sixty days of the youth's anticipated stay, youth's responsibilities to accomplish goals, program staff responsibilities to enable youth to complete goals, target dates for goal completion, and the youth's recreation plan.

Five youth case management records included documentation the transmittal letters and copies of the individualized performance plans were sent to the committing courts, juvenile probation officer, parent/guardian, and the DCF case worker, if applicable. Five youth interviews were conducted and each reported they participated in their individualized performance plans, knowledgeable of their current performance plan goals, and received a current 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.	

Performance plans and reviews shall result in revisions to the youth's performance plan when determined necessary by the intervention and treatment team. Three of the five reviewed youth case management records required an updated performance plan based upon RAY reassessment results. Two youth required an updated performance plan based upon newly acquired/revealed information warrants. All documentation was located within the youth's case management records. Three youth individualized performance plans were revised based upon the youth's demonstrated progress toward completing a goal, a youth's demonstrated lack of progress toward completing a goal, and to facilitate transition activities during the last sixty days of the youth's stay. All of the youths' individualized performance plans included transition activities from the initial performance plan to the current performance plan reviewed.

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

A review of five youth case management records indicated three of the five youth required performance summaries. All three performance summaries were completed within ninety-days following the signing of the initial performance plan. Each reviewed performance summary

included the youth's status on each performance plan goal, overall treatment progress, academic status, grades in progress and credits earned in the program if the youth is a high school student, including performance, and behavior in school, youth's behavior, level of motivation/readiness to change, interaction with peers and staff, overall behavior adjustment to the program, and significant positive and negative events. Three performance summaries included youth comments and signatures, the youth were provided a copy of the performance summary, and the original was filed in the youth's case management record.

Three performance summaries reviewed were signed and dated by the treatment team leader, staff member preparing the summary, program director or designee, and youth. Three youth case management records included documentation a copy of the performance summaries was sent within ten working days to the committing court, youth's juvenile probation officer (JPO), youth, parent/guardian, and DCF caseworker, if applicable.

The transmittal letters reviewed had "progress report" which the clinical director confirmed was the performance summary. A recommendation was provided to the program for "performance summary" to be specifically written in the transmittal letters.

Three closed youth case management records were reviewed and documentation was included in the closed case management records the original performance summaries, along with justification for release were sent with the pre-release notification to the JPO. All three release summaries were sent with the pre-release notification at least forty-five days prior to planned release and a signed copy was retained in the closed youth's case management record.
Three closed youth case management records contained documentation the program provided written notification to the youth's parent/guardian of planned released. Once the pre-release notification was approved, an exit Residential Assessment of Youth (RAY) was completed once the youth left the program. Three closed youth case management records contained documentation the JPO was notified of release within thirty days of release.
Three closed youth case management records contained documentation the youth's performance summary, transition plan, and any psychological/psychiatric reports completed while in the program were provided to the JPO upon the youth's completion of the program.
One of three closed youth case management records contained documentation of a victim notification of release letter. Two of the closed youth case management records contained documentation the victim notification of release letters was waived.

Three of five interviewed youth indicated they received a copy of their performance summaries.

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

The program encourages and facilitates involvement of the youth's parent/guardian in the case management process. Five youth case management records were reviewed for parental involvement in case management services. All five youth case management records included documentation of parent/guardian involvement in the assessment process, development of the youth's performance plan, formal treatment team meetings, advanced notice of the youth's treatment team meeting dates and times, transition planning, and documentation the parent/guardian was able to participate by telephone when unable to attend in person.

Two treatment team meetings were observed during the week of the annual compliance review.. The program sends letters to the parent/guardian with the dates, times, and contact information of the youth's treatment teams. The parent/guardian is also notified through monthly telephone contacts.

An interview conducted with the program director indicated all of the youth's parent/guardians are provided copies of the youth's performance plan and updated at least monthly in formal treatment teams to hear about the youth's progress to include behaviors, grades, education status, medications, health issues, mental health, timeline for release, and about any incidents having taken place. The performance plans are mailed out and information is provided in letters to inform the parent/guardian of the dates and times of the treatment team meetings.
Five youth were interviewed and reported their parent/guardians participate through treatment teams.

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

The treatment team includes the treatment team leader, youth, administrative representative, living unit representative, treatment staff, educational staff, Department of Children and Families (DCF) caseworker or Agency for Persons with Disabilities (APD) waiver support coordinator, if applicable, juvenile probation officer (JPO), parent/guardian, program's gang prevention specialist if applicable, and human trafficking-specific service provider, if applicable.

Five youth case management records were reviewed and each record contained documentation each treatment team member was present during formal treatment team meetings. Observation of the treatment team included a documented gang member; however, the program's gang prevention specialist was not present during this specific treatment team. The gang prevention specialist's signature was on other treatment team documentation. The transition specialist is also involved in all formal treatment teams which was documented through signatures.

Five youth case management records included the youth's JPO, parent/guardian, and other pertinent parties were invited and encouraged through advance notification to participate in treatment team meetings.. If participation could not be arranged, the individuals were provided the opportunity to provide input either verbally or through written communication. Five youth case management records included documentation of the youth, program administration representatives, living unit representatives, and all other directly responsible for providing or overseeing provision of intervention and treatment to the youth..

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

The youth's performance plan shall reference or incorporate the youth's treatment or care plan. Five youth case management records were reviewed and contained documentation the youth had additional plans included in the individualized performance plans. These additional plans included academic plans and treatment plans. Two of the reviewed youth records were involved in the Department of Children and Families (DCF) and were provided a separate DCF case

plan. Two youth case management records included reference of the DCF case plans for the youth.

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

The program shall ensure the intervention and treatment team meets bi-weekly, formally and informally to review each youth's performance to include Residential Assessment for Youth (RAY) reassessment results, progress on individualized performance plan goals, positive and negative behavior including behavior resulting in physical interventions, and a review of their treatment plans.

A review of five youth case management records included documentation of formal treatment team reviews were held at least every thirty days. All formal and informal treatment team reviews were documented in the youth's case management record and included the youth's name, date of review, comments from treatment team members, brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, and RAY reassessment results. Five youth case management records included documentation the youth were provided an opportunity to demonstrate skills acquired in the program. Each of the reviewed youth case management records included documentation informal reviews were held bi-weekly. All informal treatment team reviews were documented in the youth's case management record and included the youth's name, date of review, meeting attendees, any comments from treatment team members, brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, and RAY reassessment results. Each of the reviewed youth case management records included documentation the youth were provided the opportunity to demonstrate skills acquired in the program.

A treatment team meeting was observed and copies of the treatment plans were provided for review. All required staff were present with the exception of education and the gang specialist. Input from education and the gang specialist were provided for the treatment team observed. A review of treatment team documentation included the youth's progress on performance plan goals, positive and negative behaviors, any behaviors resulting in physical interventions, youth's treatment progress, all members actively participated in the treatment team meetings, and the youth were provided an opportunity to demonstrate skills acquired in the program. The youth's treatment plan was reviewed to determine the youth's anticipated release date along with a review of the Juvenile Justice Information System (JJIS) anticipated release date to ensure it is updated at least every ninety days and at the sixty-day transition conference.

Five youth interviews were conducted and each reported being given an opportunity during treatment team meetings to demonstrate skills learned in the program and staff reviewed the youth performance to include progress on performance plan goals, positive negative behavior, and treatment progress.

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

Three closed youth case management records were reviewed and contained documentation of employability being a goal on the youth's individualized performance plans. These provisions included for continuation of education and/or employment, a sample completed employment application or documentation confirming one was completed online, a resume' summarizing education, work experience, and/or career training, and documentation indicating the location and business hours of a local Career Source Center. Two of the three closed youth case management records reviewed contained documentation of appropriate documents essential to obtaining employment and a valid Florida identification card. The remaining youth's case management record had documentation the parent/guardian did not send the appropriate forms to the program for the youth to obtain a valid Florida identification card. Documentation of requests to the parent/guardian were located and reviewed in the youth's case management record.

Three closed youth case management records included documentation the youth's parent/guardian and juvenile probation officer were aware of the vocational plan for the youth and there was evidence the youth's case manager and parent/guardian was aware of the plan, documents, and post-release discharge plans.

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 personal accountability skills, behaviors leading to appropriate work habits for employment and living standards and provides program content and an orientation on career choices, based upon personal abilities, aptitudes, communication, interpersonal, decision-making skills, and interests.

The program director interview indicated the program offers first aid, cardiopulmonary resuscitation (CPR), and Safe Serve. High school tech offers certification for youth and post-secondary education is offered through Ivy Tech Community College. The program's lead teacher interview indicated youth are offered a career assessment which is provided during the intake transition and documented in the youth's educational record. Courses include internet business associate and social media specialist. Florida Ready to Work and My Florida Shines programs are also utilized.

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

The program's logbooks, school and program schedule was reviewed to determine compliance for educational access. The program is required to provide 250 days of instruction, distributed over twelve months. Youth receive credits for the educational and training experience. Five youth were interviewed to ensure minimal interference of education instruction. Four indicated there were no interruptions during school. One youth responded there were interruptions during school. The lead teacher was interviewed to determine what the education instruction schedule is for the program and the information provided matched the program's educational schedule and program schedule.

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

Three closed youth case management records were reviewed to determine if the transition plans contained appropriate goals at the time of release. All three closed youth case management records had documentation an individual education plan was developed with the youth based upon the youth's post release goals, upon admission. The youth, parent/guardian, instructional personnel in the program, department personnel, personnel from the post-release school district, and certified school counselor were included in the transition activities. A transition plan was developed with the youth and program, education, and aftercare staff with specific plans for continuation of education and/or employment.

Three education transition plans included at a minimum services and intervention based on the student's assessed educational needs and post-release education plans, recommended educational placement for post release based on individual needs and performance, and specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services.

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

Three closed youth case management records were reviewed for youth who participated in a transition conference. Each of the three reviewed youth participated in a transition conference held at least sixty days prior to the targeted release date. The following intervention and treatment team members The youth, treatment team leader, program director or designee, and other team members attended the transition conference as evidenced by signatures reviewed. The youth's juvenile probation officer (JPO), parent/guardian, education staff, and other pertinent parties were invited and encouraged to participate through written notification and verbal notification which was documented within the youth's case management record.

Three closed youth case management records had documentation the transition conference participants reviewed transition activities on the youth's performance plan, revised the performance plan if necessary, identified additional transition activities as needed, identified target completion dates, and identified persons responsible for completion. The treatment team leader obtained attendees' dated signatures, representing their acknowledgement of the

transition goals and accountability for completion in all three closed youth case management records reviewed. A copy of the plan was sent with a request for return with signature to anyone not in attendance who has responsibility for completion of transition goals as documented through email receipts and sent letters documented in the case management records. Each of the three closed case management records included documentation a Community Re-Entry Team (CRT) meeting was held prior to the youth's release with the youth and case manager in attendance. An invitation to the CRT was documented in all three closed youth case management records.

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

Three closed youth case management records were reviewed to ensure all required documentation was assembled for the youth's exit portfolio. Each of the three closed youth case management records included documentation the youth's exit portfolio was discussed and initiated at the transition conference. A copy of the youth's transition plan, calendar with all dates/times/locations of upcoming community appointments, educational and/or vocational certificates earned in the program, all educational records and documents, school transcripts, resume', and a completed sample employment application were included in the exit portfolio for all three youth.

Two of the three records included a state-issued identification card, social security card, and birth certificate. Upon further discussion with the remaining youth's case manager, the parent/guardian of the youth never submitted the proper documentation for the youth to obtain a state-issued identification card. There was documentation in the youth's case management record of written requests to the parent/guardian for these items. Three closed youth case management records included documentation the youth's exit portfolio was verified at the exit conference. All three exit portfolios were completed and provided to the youth upon release as evidenced by a signature page signed by the youth, parent/guardian, and case manager. There was documentation in the case management records the staff forwarded the exit portfolio to the juvenile probation officer.

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

Three closed youth case management records were reviewed to determine if the exit conference was conducted with the pertinent parties within the required time frames. Each reviewed record included documentation the exit conference dates were conducted after the program notified the juvenile probation officer (JPO) of the date of release. The exit conference in all three records was conducted at least fourteen days prior to release including dates, signatures, and a summary of pending transition goals. The dates of admission and dates of termination were documented in the case management record and correlated with the Juvenile Justice Information System (JJIS). The status of transition activities were established and reviewed at the transition conference and finalized at the exit conference. : The intervention and treatment team leader, parent/guardian JPO, youth, and other pertinent parties participated in the exit conference as evidenced by signatures. Education was not present at one of the three

exit conferences due to the COVID-19 pandemic protocols; however, input was documented on the exit conference form.

All three exit conferences were separate from the transition and community re-entry team meetings.

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

Five youth case management records were reviewed to ensure the program conducted an on-going safety plan for each youth. The program maintained a safety plan for each youth located in the control room which included warning signs a youth is escalating, youth's baseline behaviors as gathered from collateral contacts, parent/guardian, youth's history, evaluations, crisis recognition, jointly developed coping strategies, intervention strategies preferred by the youth, and debriefing preferences.

Five youth case management records were reviewed along with the safety plan binder maintained by the therapy staff at the program. Five safety plans were completed within fourteen days upon the youth admission to the program. The safety plans were jointly prepared by the youth, parent/guardian, family members, program's clinical staff, and behavioral specialist, if applicable as evidenced by signatures and information documented on the safety plans reviewed. The reviewed safety plans included recommendations from previous or current clinical assessments or screening instruments and shall incorporate trauma responsive practices. Each of the five youth case management records and the safety plan binder included documentation the safety plans were updated every thirty days or following any significant behavioral or mental health event identified by the youth's intervention and treatment team.

Five interviewed youth indicated participation in the development of their safety plans. Five interviewed staff indicated mixed results of their knowledge of safety plans; however, the clinical director provided documentation of the youth's safety plans being reviewed during all team meetings on a weekly basis. Staff are required to sign the sign-in sheets for the all team meetings.

Standard 3: Mental Health and Substance Abuse Services

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

The designated mental health clinician authority (DMHCA) is a licensed mental health counselor and licensed under Chapter 459.. The DMHCA's license expires on March 31, 2021A review of the Youth Opportunity Investments LLC. time and attendance log, the DMHCA was on-site forty hours a week, five days a week, eight hours or more a day. The DMHCA was on-site in enough time to provide appropriate services and to implement mental health and substance abuse services. The program utilizes a licensed mental health counselor as the back-up to the DMHCA. The back-up DMHCA is licensed under Chapter 459, expiring on March 08, 2023. The DMHCA reported their role is to provide direct supervision of all mental health and substance abuse services. The program utilizes the DMHCA and not a clinical coordinator for training in mental health and substance abuse services.

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

The program utilizes two licensed staff to provide services at the program. One licensed staff serves as the designated mental health clinician authority (DMHCA) and the remaining staff is a licensed mental health counselor (LMHC). The LMHC is licensed under Chapter 459 and expires on March 8, 2023.

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

The program's policy addressed mental health and substance abuse services are provided by individuals with appropriate qualifications. A review of the staff roster determined staffing is in accordance with the contract. The program utilizes four non-licensed clinical staff identified as therapists. A review of educational and training requirements for non-licensed clinical staff

determined each of the staff have the appropriate training and education. Each staff provided documentation of a master-level education in counseling or human related field.
The facility is licensed under Chapter 397 expiring on April 01, 2021. Each non-licensed staff had documentation of being directly supervised by the designated mental health clinician authority (DMHCA). Documentation included the previous six months.

Each staff held a master's-level degree from an accredited university. Each non-licensed mental health clinical staff had twenty hours of training and supervised experience in assessing suicide risks, since each staff provides substance abuse services, each staff reviewed had training in accordance with Rule 65D-30.

The DMHCA maintained a supervision log with a minimum of one hour a week of on-site face to face interactions with the non-licensed mental professionals. The purpose of the DMHCA's direct supervision is to provided oversight, as defined in Section 397.311. The direct supervision was recorded on the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log. The DMHCA is also responsible for reviewing the Assessment of Suicide Risks, crisis assessments, and follow-up crisis assessments. The DMHCA is responsible for signing each assessment.

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

The program completes mental health and substance abuse intake forms ensuring youth needs are identified and referrals are completed as part of the screening process. The program utilizes the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) and Assessment of Suicide Risk (ASR). A review of the facility's operating procedures (FOPs) determined the program implemented a standardized admission/intake mental health and substance abuse screening process.

A review of five youth mental health and substance abuse records confirmed the program reviewed the commitment packet information, reports, and Juvenile Justice Information System's (JJIS) alerts. Any existing mental health or substance abuse problems were documented for each of the five youth. The MAYSI-2 was administered in the JJIS on the day of admission and received an ASR. Each youth MAYSI-2 scoring had indicated a need for further assessments which the program completed a referral. None of the youth were in crisis during the screening process. An ASR was completed for each youth within twenty-four hours which the MAYSI-2 category indicated a need for further assessment or other information obtained indicating a need. The clinical mental health and substance abuse intake form was administered upon each of the five youth's admission in the program. All screenings were signed by the designated mental health clinician authority (DMHCA) or licensed staff. None of the screenings determined an emergency. The staff documented a consultation with the DMHCA for each of the five youth records reviewed.

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

The program's policy was reviewed. Youth at the program identified by screenings in need of further evaluations must be referred for a comprehensive mental health evaluation and/or comprehensive substance abuse evaluation. Five youth mental health and substance abuse records were reviewed. Each of the youth were identified at screening as in need of further evaluation. Each of the youth had a new comprehensive evaluation completed within thirty calendar days of admission. Each evaluation was reviewed by the designated mental health clinician authority (DMHCA) or licensed qualified professional within ten calendar days after the evaluations were conducted. Each of the evaluations had new information applicable to each youth based upon current information provided by the youth, parent/guardian, and youth's records.

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

Mental health and substance abuse treatment planning is required as delineated in the program's policy. The policy focuses on individualized, trauma informed, developmentally appropriate mental health, substance abuse, and developmental disability treatment services to all program youth in need of such services. All treatment services are guided by an individualized treatment plan.

Five youth mental health and substance abuse (MHSA) records were reviewed. Each of the youth were assigned to a treatment team upon admission to the program. The team comprised of the youth, program administration, education, living unit representatives, juvenile probation officer (JPO), and the parent/guardian. Each of the youth were determined in need of mental health treatment and substance abuse services. Each youth MHSA had documentation the youth received individual therapy, group therapy, and family counselling.

The facility is licensed under Chapter 397 which expires on April 01, 2021. The program has four non-licensed staff. Each non-licensed staff had documentation of being directly supervised by the designated mental health clinician authority (DMHCA). Each of the youth reviewed were receiving mental health treatment and substance abuse services in accordance with the youth's treatment plan. Each of the five youth received individual, group, and family counseling by the clinical director or the non-licensed staff. Each of the youth signed consent treatment forms. None of the youth required a court order for substance abuse evaluation and treatment. Each youth had documentation of a properly executed Authority for Evaluation and Treatment (AET). All treatment notes were documented on the Counseling/Therapy Progress Notes form.. Each of the youth were receiving dual treatment of mental health and substance abuse services. Each youth had signed consents forms for substance abuse treatment and a signed form for youth

consent release forms on the appropriate Department forms. Each youth signature was present on all individual, family, and group therapy documentation. A review of the sign-sheets for family counseling determined when the family was available. The program provided family counseling monthly. Observation of group therapy during the week of the annual compliance review, determined groups were held with fewer than ten participants.

Five staff were interviewed and each direct care staff reported they do not facilitate any mental health or substance abuse education groups. Five youth were interviewed and each youth reported they participate in counseling weekly. The DMHCA reported individual therapy is provided four times a month, as well as needed and group therapy is provided daily.

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

According to the program's policy, all treatment services are guided by an individualized treatment plan, as it addresses the youth's needs in accordance with F.A.C. 63N-1. Procedurally, it is the responsibility of the designated mental health clinician authority (DMHCA), mental health and substance abuse clinical staff , and other multidisciplinary treatment team members to ensure all treatment plans are individualized and relevant to each youth's specific needs. The policy also addresses youth receiving discharge mental health/substance abuse treatment plan, including recommendations. The Mental Health/Substance Abuse Treatment Discharge Summary addresses the start and end dates of mental health and substance abuse treatment, relevant mental health and/or substance abuse history, reason for termination of mental health and/or substance abuse treatment, any problems which were focus of mental health and/or substance abuse treatment, a summary of mental health and/or substance abuse treatment, youth's progress in treatment, beginning and ending diagnoses, any psychotropic medications the youth has been receiving and to be continued upon discharge, and continued mental health treatment and/or substance abuse treatment upon transition or discharge.

Five youth mental health and substance abuse records were reviewed. An initial treatment plan was developed within thirty days of each of the youth's admission. An initial treatment plan was developed on the Initial Mental Health/Substance Abuse Treatment Plan) for each of youth receiving a mental health/substance abuse service. Each youth needed both mental health treatment/substance abuse services and a plan was developed within seven days of the onset of treatment. Three of the five youth were prescribed psychotropic medication. The program provided treatment within seven days of the Initial Psychiatric Diagnostic Interview for each of the three reviewed youth. Individualized treatment plans were signed by the mental health clinical staff person and the appropriate treatment team members. Psychiatric services for the three youth was included in the initial treatment plan. Each youth had their individualized treatment plan completed on the Individualized Mental Health/Substance Abuse Treatment Plan

and the plan reviews were completed on the Individualized Mental Health Treatment Plan Review.

Three closed youth records were reviewed in addition to the five open youth records. Each of the three closed youth records received mental health/substance abuse services while in the program. Each of the three youth had a discharge plan documented on the Mental Health/Substance Abuse Treatment Discharge Summary. None of the youth were released on suicide risk during the scope of the review. The service needs of the youth were documented on the discharge plan. The Mental Health/Substances Abuse Treatment Discharge Summary considered services such as therapy and substance abuse therapy. Documentation included the summary being provided to the juvenile probation office (JPO), parent/guardian, and the youth. Exit staffing dates and discharge plan dates determined available for review. Exit staffing documented the discussion of the Mental Health/Substance Abuse Treatment Discharge Summary with all appropriate parties prior to the youth's release date.

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

The program director and the designated mental health clinician authority (DMHCA) reported the program provides borderline developmental disability/developmental disability services to the youth at the program. The program's treatment services are provided in accordance with Florida Statutes, Administrative Rule, and the provider's contract. The focus of treatment services includes targeting and reducing/alleviating the youth's symptoms of mental health and substance abuse related disorders. Developmental disability treatment services are provided for youth with an intelligence quotient less than seventy and whose level of impairment and related functional limitations impede their ability to function.

Youth designated for developmental disability services receive a minimum of individual and family therapy and psychiatric services when applicable, along with medication management. The therapy models includes Skillstreaming the Adolescent which is integrated into group therapy sessions, Trauma Focused Cognitive Behavioral Therapy, Young Men's Work- gender specific, and Life Skills Training. A review of the contract and five youth mental health and substance records determined each youth treatment plan was in accordance with the contract and the program's therapy model. The therapist documented the model utilized with the youth along with the type of therapy the youth was receiving during the session such as trauma focus or skillsstreaming.

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

Psychiatric services at the program are provided by a psychiatrist. The psychiatrist is a licensed physician under Chapter 458. Five youth mental health and substance abuse (MHSA) records

were reviewed. Two of the five youth were prescribed psychotropic medication. A review of the sign-in sheets during the annual compliance review period determined the psychiatrist was on-site bi-monthly, every other week which was confirmed by an interview with the psychiatrist. An additional youth record was reviewed to meet the minimum requirement of three youth records for review. Two youth entered the program on psychotropic medication. The remaining youth was prescribed psychotropic medication while at the program. The initial diagnostic interview was completed within fourteen days for each of the youth. Diagnostic contained all the elements specified in Rule 63N-1 for each of the youth. A psychiatric evaluation was conducted within thirty days of intake and had documentation of monthly medication review for each of the three youth. The psychiatrist had documentation of a brief representative in treatment team on the psychiatric status for each of the three youth.

For each youth, the program had documentation of the psychiatrist completing the Clinical Psychotropic Progress Note, page three. For each of the three youth reviewed; the psychiatrist documented the identifying data, diagnosis, target symptoms, evaluation for each of the three youth, prescribed psychotropic medication, side effects, youth's adherence to the medication regime, telephone contact with the youth's parent/guardian, signature of the psychiatrist, and the date of signature. Each youth provided consent. The psychiatrist reported being on-site two days a week, as a review of the sign-in sheets validated this occurrence.

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

The program has a written plan delineating the suicide prevention procedures. The plan included all the appropriate procedures. The program administrator reported mock drills are conducted quarterly for all staff. The policy includes maintaining one-to-one supervision or constant supervision during suicide precautions. Procedures for the policy includes making a referral, communication with mental health staff, completing notifications to program, updating and documenting the Juvenile Justice Information System, provisions for immediate staff responses, and a mental health review process. The suicide prevention plan is maintained and reviewed at least annually by the program director (PD). The PD reviewed the plan in 2020. If any suicide risk factors are indicated during screening, the youth is placed on suicide precautions and constant supervision. The licensed mental health professional will conduct or supervise the Assessment of Suicide Risk (ASR). A suicide risk alert is completed by clinical staff. Youth will be removed from precautionary observation and stepped down to close supervision. The staff assigned to monitor the youth on suicide precautions will maintain on one-to-one supervision or constant supervision of the youth and document observations on the Suicide Precautions Observation Log . A referral summary is completed. The PD or designee will review the ASR's findings. All staff working with youth must receive six hours of annual training on suicide prevention. The suicide prevention plan is maintained in a binder in master control.

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

Five youth mental health and substance records were reviewed. Two of the five youth were placed on suicide precautions. An additional youth records was reviewed to meet the minimum requirement of three youth records. Precautionary observations were maintained for each of the three youth until an Assessment of Suicide Risk (ASR) was completed. The ASR indicated precautionary observation could be discontinued for two of the three youth reviewed. One youth required a follow up ASR. The program does not utilize secure observation.
The program has written policy and procedures to address serious suicide attempt or serious self-inflicted injury to include a mortality review for a completed suicide.

Each of the ASRs were documented in real time on the appropriate form. Each of the ASRs were completed within twenty-four hours. A review of logbooks determined the beginning and ending times were documented for placing the youth on precautionary observations. Each of the ASRs were completed by the non-licensed clinical staff and reviewed by the designated medical health clinical authority (DMHCA). Youth were not lowered or discontinued until the non-licensed staff conferred with the DMHCA. The one youth whom ASR indicated a potential suicide risk was maintained on suicide precautions and constant supervision, until the follow-up ASR indicated suicide precautions may be discontinued. The Follow-Up ASR was recorded on the Follow-Up Assessment of Suicide Risk form. The parent/guardian were notified for one of the youth and the remaining two youth were not initially placed on suicide precautions at the program. The program was not required to complete a notification but the initiating detention center was required to complete a notification. The Department's Juvenile Justice Information System (JJIS) determined alerts were appropriately entered when applicable. The program utilizes the non-licensed clinical staff. Each of the non-licensed staff completed the required twenty hours of training and five supervised assessments under the direct supervision of DMHCA.

A random interview with three direct care staff determined each staff were knowledgeable of the appropriate steps to follow if a youth expresses or displays warning signs. Each of the staff reported warning signs may include youth receiving bad news or a youth verbally stating they want to hurt themselves. The staff reported they will complete a notification to mental health staff and place the youth on constant supervision immediately. Five interviewed staff reported if a youth expresses suicidal thoughts it is their responsibility to notify mental health, supervise the youth, and document the supervision of the youth. None of the staff reported placing the youth in a locked room.

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

Five youth mental health and substance abuse records were reviewed. Two of the five youth reviewed were placed on suicide precautions. An additional youth record was reviewed to meet the minimum requirement of three youth records. The three reviewed youth records were not placed in a secure observation room as the program does not utilize secure observation rooms. In each record, the suicide precaution observation logs were completed, maintained in real time, warning signs were noted, and reviewed and signed by mental health staff daily. Each of the three youth were maintained on constant supervision while on suicide precautions. The direct care staff supervising the three youth, maintained the appropriate level of supervision and recorded the youth's behavior on the logs. Informal interviews with two of the youth determined staff always supervised the youth while on suicide precautions.

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

Eleven staff training records were reviewed which ten staff received the required six hours of annual training on suicide prevention and implementation of suicide precautions. One staff completed four hours of training. Training included mock suicide drills which were held no less than quarterly on each of the three shifts. A total of thirteen direct-care staff were reviewed and mock drills were completed for each of the three shifts. Reviewed documentation confirmed thirteen of the seventeen direct care staff participated in the mock drills. The program provided documentation the remaining four staff were no longer employed with the program or were not employed long enough to participate in each of the quarterly mock suicide drills. Reviewed documentation confirmed each reviewed staff participated in at least one drill requiring cardiopulmonary resuscitation (CPR) for each of the three shifts. The program director (PD) reported drills are held no less than quarterly and each staff reviews the mock suicide drill during their monthly staff meetings. The PD stated if staff are knowledgeable of what procedures to follow during an actual suicide attempt, the staff can appropriately and swiftly react alleviating any doubt of what to do.

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

The program has a written crisis intervention plan delineating the crisis intervention procedures including verbal de-escalation and protective action response (PAR), notification and alert system, referrals including youth self-referral, crisis assessment and follow-up mental status examination (MSE), communication, supervision, mental health supportive services, and

documentation and review. Verbal de-escalation and PAR will be conducted for youth who exhibits any signs of a crisis. Staff are required to follow the PAR matrix for intervention. Notifications are completed to the youth's parent/guardian and juvenile probation officer (JPO). The alert system is updated as the youth are placed on a mental health alert and the assistance of a mental health professionals is required according to policy. The program's policy indicates a referral to mental health clinical staff for a crisis assessment is made by using the Mental Health/Substance Abuse Referral Summary. The program's policy indicates a crisis assessment is completed by a licensed mental health professional within twenty-four hours of referral and a follow-up mental status examination. Communication regarding the status of the youth are completed at shift briefings, management meetings, logbook entries, alert board, e-mail and telephone calls. Youth are supervised on one to one, constant supervision, or close supervision. Mental health supportive services include therapeutic activities such as counseling crisis counseling, crisis assessment, or an MSE. The program director or designee's signature is required on the Crisis Assessment as it ensures procedures are followed and implemented.

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

Youth who are experiencing emotional or psychological distress are address in the program's crisis intervention plan. The program defines crisis as youth experiencing acute emotional or psychological distress. The program did not have any Crisis Assessments since the last annual compliance review. A review of the program's policy, Crisis Assessment tool, and staff training records determined the program is adequately prepared to conduct Crisis Assessments.

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

According to the program's emergency care plan, the emergency response plan for mental health and substance abuse emergency policy highlights safety and management of the youth. The purpose of the policy is to ensure youth determined to be an imminent danger to themselves or others due to mental illness or substance abuse impairment receive emergency care. The plan delineates facility operation procedures for emergency mental health and substance abuse services, Baker and Marchman Acts. The plan includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Ch. 394 F.S. (Baker Act), transport for emergency substance abuse

assessment and treatment under Ch. 397 F.S. (Marchman Act), documentation, training, and review.

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

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

Standard 4: Health Services

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

The program has a licensed physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida who serves as the designated health authority (DHA). The DHA's license expires on January 31, 2022 and has a specialty training in family practice. The program does not have a physician assistant or an advanced practice registered nurse (APRN). The DHA is scheduled to be on-site every week for two hours per visit. The DHA's role at the program is to conduct Comprehensive Physical Assessments (CPA) weekly as need and periodic evaluations every three months for youth with chronic conditions. Sick calls are performed by nurses and referred to the DHA as needed. The DHA also develops and review policies for the program. A review of the sign-in logs for the previous six months prior to the annual compliance review, confirmed the DHA was on-site weekly for at least two hours on Monday's. The DHA is also available twenty-four hours a day, seven days a week by telephone to address concerns at the program. When the DHA is on vacation or has scheduled absences, coverage is arranged by the DHA. A review of all licensed medical staff confirmed each had current State of Florida medical licenses, verified by the Department of Health.

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

The program has facility operating procedures (FOPs) and treatment protocols for all health-related concerns. The FOPs were found to be well organized in a three-ring binder. The policies, procedures, and treatment protocols were reviewed and signed by the designated health authority (DHA). There was no documentation of an annual review of all FOPs and protocols as required. All FOPs and treatment protocols contained the signature of the DHA and the program director dated, August 01,2018. There was documentation of all newly employed healthcare personnel receiving a comprehensive clinical orientation to the Department's healthcare policies and procedures which was provided by the registered nurse. Documentation confirmed nursing staff completed the annual review of FOPs and signed the cover page. The review and development of FOPs or other protocols related to psychiatric services and psychotropic medication management were only performed by the program's psychiatrist.

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

A review of five youth individual healthcare records (IHCR) found each record contained an Authority for Evaluation and Treatment (AET). Three of the IHCR contained an original AET and two contained a legible copy of the original AET with the word "Copy" stamped on the AET. Copies of completed parental notifications were maintained behind the AET in the IHCR. One youth was in the care of the Department of Children and Families (DCF) and the court authorized all treatment and procedures. The nurse revealed eighteen-year-old youth are

responsible for authorizing their health and responsible for accepting and providing consent for care. The registered nurse revealed the AET or court order is obtained off the Department's Juvenile Justice Information System (JJIS) and filed in the healthcare record with a copy stamp.

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

A review of five youth individual healthcare records (IHCRs) found each record contained parental notifications. Two youth had parental notifications for over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET). Each of the youth had parental notifications for vaccinations or immunizations not consented for on the AET form. Two of the youth were taken off-site for medical treatment and there was documentation of a parental notification in each of the IHCR. One youth had a parental notification for off-site emergency care. There was documentation of verbal attempts in two of the youth's IHCR for new mediation. For each parental notification, there was documentation of telephone calls, attempts, and verbal approvals which were witnessed. A review of the youth IHCR revealed vaccinations were verified within thirty days of the youth admission. The registered nurse revealed parental notifications are required for a new medication order or change in a medication order. The program also requires notification when there is a change in the youth's health status. The nurse revealed parental notifications are completed immediately for any change, verbally and written with a witness present for consent. Immunization records are obtained from the Department's Juvenile Justice Information System (JJIS) under electronic commitment packet and Florida Shots.

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

A review of five youth individual healthcare records (IHCR) found a Facility Entry Physical Health Screening Form (FEPHS) was completed on the date of admission for each youth. The screening was completed by the registered nurse (RN). There were no youth at the program requiring a rescreening.

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

A review of five youth individual healthcare records (IHCR) found each youth received a general care orientation upon admission to the program. The healthcare topics included access to medical, how to use and access sick call , what constitutes an "emergency" and who to notify, medication process and side effect monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers. Each youth signed a form along with the nurse documenting the youth received an orientation. The Health Education form was reviewed for documentation of topics covered.

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

A review of five youth individual healthcare records (IHCR) found two youth were applicable for a known or suspected chronic condition. Additional records were requested and one was provided. Neither of the youth were identified in need of an emergency response. The designated health authority (DHA) was notified by telephone for each youth. Each notification was documented in the youth's chronological progress notes in the IHCR.

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

A review of five youth individual healthcare records (IHCR) found each youth had an updated or completed health-related history (HRH) within seven days of admission and prior to the Comprehensive Physical Assessment (CPA). Each of the HRH was completed by a licensed nurse or the practitioner and reviewed by the designated health authority (DHA) as noted on the CPA for each youth. The registered nurse revealed the HRH is completed by the licensed nurse or practitioner within seven days of admission.

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

The program has a policy and procedures in place related to Comprehensive Physical Assessment (CPA). A review of five youth individual healthcare records (IHCR) found the program utilized the Department's CPA form for each youth. Each of the CPAs were completed within seven days by the designated health authority (DHA). Each youth's medical grade was documented on the CPA. All sections of the CPA were marked with an "O" or an "X". For any part of the exam which was refused by the youth, the doctor wrote "Youth Refused". The youth signed on the CPA stating they refused. The Department's Problem List was updated for each youth.
The program has a policy and procedures in place discussing tuberculosis skin test (TST). A review of five youth IHCRs revealed there was at least one verified TST documented in the individual healthcare record on the Infectious and Communicable Diseases (ICD) form and the Facility Entry Physical Health Screening form (FEPHS). The results of the TST documented on the CPA and ICD forms matched. The nurse revealed TST screening are conducted annually. The registered nurse revealed TST screenings are completed within seventy-two hours of admission.

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

The program has a policy and procedures related to sexually transmitted infection (STI) and human immunodeficiency viruses (HIV) screenings. A review of five youth individual healthcare

records (IHCR) found each of the youth were screened and evaluated for STIs. The nurse revealed youth are screened for STIs using Department's Sexually Transmitted Infections Screening form. The nurse stated upon admission youth who are sexually active are screened for STIs and if a youth has been out of the Departments custody or have signs and symptoms of a STI, they are screened. Testing was not ordered for any of the youth. Screening results, clinical evaluation, and diagnosis were documented on the Department's Infectious and Communicable Diseases (ICD) form and filed in the lab section of the youth IHCRs when applicable. There was evidence in each youth's record of the youth being offered counseling, testing, and treatment in each of the five IHCRs. The program utilizes OASIS Florida to conduct HIV education and testing.

There was documentation of all five youth consenting to HIV testing. Documentation of pre-test and/or post-test counseling was documented on the Individual Health Education Record for four of the five youth. The remaining youth initially gave consent for testing changed their mind and signed a refusal form. The test results for the four youth were filed in a sealed envelope marked "CONFIDENTIAL" consistent with Florida Statue 381.004. There was proof of review by a practitioner documented on the sealed envelope. None of the youth's HIV statuses were documented in the internal alert system. Each of the youth signed a consent/release form stating the individuals to whom information should be released to. The program's copy of the providers 500/501 certification by Department of Health was reviewed and found to be valid. Five interviewed youth stated they can request a HIV test.

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

A review of five youth individual healthcare records (IHCR) found three youth had a least one sick call request. None of the youth presented similar sick call complaints three or more times within a two-week period. None of the three youth complained of any severe pain with which staff was unfamiliar. Once a youth completes a sick call, the request is place in a locked box in a secure location inaccessible to youth. The request is then provided to the nurse. Each of the sick calls were documented on the Sick Call Index and Sick Call Referral Log. A review of each IHCR found the registered nurse completed sick call request forms and filed the forms with the progress notes in the youth record in reverse chronological order. The program has procedures in place when the licensed nurse is not on-site to review sick call request within four hours after the request is submitted. If the licensed nurse is not on-site, the shift supervisor reviews all sick call requests no longer than two hours after the request was submitted. All complaints of severe pain are treated as an emergency and the licensed health care professional is notified. A tour of the program found sick call request forms were found on each of the youth living areas. An exam table and equipment are used to perform sick calls. The program has regularly scheduled sick call posted hours. Sick call is available every day from 7:00 a.m. to 7:30 a.m., 6:00 p.m. to 7:00 p.m., and as needed. A sick call was not observed due to no sick call request placed by the youth during the week of the annual compliance review. One interviewed youth revealed they could see a nurse immediately after placing a sick call. Two youth stated they could see a nurse within one day. The remaining two youth stated they have never requested a sick call. Five interviewed staff revealed nurses responds to sick calls.

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

A review of five youth individual healthcare records (IHCR) found three youth had a least one sick call request. None of the youth presented similar sick call complaints three or more times within a two-week period. None of the three youth complained of any severe pain with which staff was unfamiliar. Once a youth completes a sick call, the request is place in a locked box in a secure location inaccessible to youth. The request is then provided to the nurse. Each of the sick calls were documented on the Sick Call Index and Sick Call Referral Log. A review of each IHCR found the registered nurse completed sick call request forms and were filed with the progress notes in the youth record in reverse chronological order. The program has procedures in place when the licensed nurse is not on-site to review sick call request within four hours after the request is submitted. If the license nurse is not on-site, the shift supervisor reviews all sick call requests no longer than two hours after the request was submitted. All complaints of severe pain are treated as an emergency and the licensed health care professional is notified.

A tour of the program found sick call request forms were found on each of the youth's living areas. And exam table and equipment are used to perform sick calls. The program has regularly scheduled sick call posted hours. Sick call is available every day from 7:00 a.m. to 7:30 a.m., 6:00 p.m. to 7:00 p.m., and as needed. A sick call was not observed due to no sick call request placed by the youth during the week of the annual compliance review. One interviewed youth revealed they could see a nurse immediately after placing a sick call. Two youth stated they could see a nurse within one day. The remaining two youth stated they have never requested a sick call. Five interviewed staff revealed nurses responds to sick calls.

The program has a total of four first aid kits with two assigned for transportation. Each of the first aid kits were stocked with DHA approved content. Three first aid kits are located in master control and the remaining first aid kit is located in the kitchen. There was documentation of the first aid kits being reviewed each month. A review of the four fist aid kits found each contained an expired content. The expired content was replaced during the week of the annual compliance review. The program has one automated external defibrillator (AED) which is located in master control. There was documentation the nursing staff completed checks on the AED monthly. The nurse conducted a self-test of the AED. The AED batteries were last changed on June 15, 2020 and expires on September 2022. The AED pads were last changed on September 15, 2020 and expires on January 24, 2023.

The program's practice is to conduct mock emergency drills monthly on every shift. The mock drills contained a simulation of an episodic care event which calls for immediate first aid and/or administration of CPR techniques and the initial of the emergency procedures to follow when a life-threatening emergency occurs. Each of the drills were maintained in a binder labeled drills. Emergency numbers were posted in the medical clinic and master control inaccessible to youth. There was documentation of supervisory staff receiving epinephrine auto-injector training which was conducted by a registered nurse. Five interviewed staff revealed they are personally allowed to call 9-1-1 if a youth has a medical emergency. Five interviewed youth revealed they can see a dentist or doctor, if needed.

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

The program has a policy and procedures in place in reference to off-site care for youth. A review of five youth individual healthcare records (IHCR) found one of the youth was applicable. Additional records were requested and two were provided. There was documentation of the youth's parent/guardians being notified. The IHCRs contained a summary of off-site care form and discharge instruction documents for each youth. The designated health authority (DHA) reviewed and signed all off-site care paperwork. One of the youth required follow-up testing, referrals, or appointments. There was documentation the referral was tracked. The youth received appropriate, timely, and follow-up care as needed.

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

The program has a written policy and procedures for the delivery of treatment to youth identified as having a chronic medical condition. A review of five youth individual healthcare records (IHCR) found two youth were identified with a chronic medical condition and/or taking prescribed medications. One additional record was requested which was provided. Neither of the youth were taking prescribed medication on and ongoing basis Two of the youth were diagnosed with asthma and the remaining youth had high cholesterol. Each of the youth were classified with a medical grade two through five. There was documentation of each youth receiving periodic evaluations at no greater than three months intervals. The periodic evaluations were tracked on the Chronic Physical Health Conditions Roster form which was found in each youth's IHCR. Documentation was also found in the progress notes located in the youth's IHCR. The designated health authority revealed periodic evaluations are conducted for youth with chronic conditions every three months. The facility administrator revealed the medical alert log is updated weekly or as needed or due to a new admission and shared with staff, food services, supervisors, and the education department. Alert boards are updated in conjunction with the log provided. Nursing staff will routinely verify all alerts in the alert systems are accurate and up to date.

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

The program has a written policy and procedures to ensure medication is received, stored, inventoried, and provided in a safe and effective manner. A review of five youth individual healthcare records (IHCR) found three youth were prescribed medication prior to their admission to the program. In each of the three IHCRs, the medication was verified by medical staff and the youth was continued on medications. There was documentation of the designated health authority (DHA) being contacted to obtain the order to resume the specified medications the youth was prescribed prior to admission. The nurse interview revealed the program used the medication verification forms to verify medications. The medication is verified by the DHA or a

pharmacist for an updated order upon admission. The medication also must be in the original containers. Only nurses verify medications upon the youth's admission.

The program utilized the standard Department's Medication Administration Record (MAR) to document consumption and refusal of medications. The MAR documented all the required information including demographic information of youth, medication start and stop dates, and staff and youth initials of medication received. There were no lapses or errors in medication administration. The medical staff documented weekly side effect monitoring on the MARs. There were no refusals documented; however, the program's practice is to document refusals on the MAR and refusal form, when applicable. A tour of the medical clinic found all medications were in a separate, secure area inaccessible to youth. Narcotics and other controlled medications were found stored behind two locks. Oral medications were not found to be stored with injectable or topical medications. Syringes and sharps were found to be secured in a cabinet. The program has a secured refrigerator designated for medication requiring refrigeration. The medication cart was found to be clean, organized, and stocked items were separated from youth specific medications. An interview with the registered nurse (RN) on duty revealed disposal and destruction of expired and/or discontinued medication requires two nurses. The medication is then placed in a solution called Rx Destroyer. The destroyed medication is documented on a log located in the medical clinical. Three interviewed youth stated the nurse gives medication to youth. The remaining two interviewed youth stated they do not currently take any medications.

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

The program has a written policy and procedures ensuring medications and sharps are secured and inventoried by using a routine perpetual inventory. A tour of the medical clinic found medications were stored in a locked medication cart, cabinets, and in the locked refrigerator. All controlled medications were found stored behind two locks. A shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record. All sharps were found secured and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed. There was documentation of a perpetual and a weekly inventory of all sharps and stock over-the-counter (OTC) medications being conducted. A random inventory of two youth medications to include one narcotic, three different sharps, and three OTC medications revealed each count was accurate and documented. A review of the previous six months medications revealed all counts and inventories matched medications. The nurses interview revealed all medications are in a locked area for storage and are separated by medication forms. Inventory is completed perpetually and on a weekly basis. Controlled substances are secured behind two locks with two separate key access.

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

The program has an infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases according to the Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control (CDC) guidelines. A review of the program's exposure control plan was conducted and confirmed the plan included all the required elements outlined in the Department's standards. The plan was reviewed and signed by the program director (PD) and designated health authority (DHA) on January 10, 2020. The PD revealed the exposure control plan is located in nursing and master control and reviewed at least annually.

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

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

4.19 Licensed Medical Staff (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according DJJ Rule as well as Facility operating procedures and nursing protocols approved by the DHA.	

The program currently has three registered nurses and a medical doctor. A review of the medical staff licenses using the Florida Department of Health's Medical Quality Assurance web site, found each license was clear and active. Each of the nursing staff have a current cardiopulmonary resuscitation (CPR) certification.

Standard 5: Safety and Security

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

The program has a written policy and procedures regarding youth supervision. The policy requires a staff-to-youth ratio of one-to-eight during daytime activities and one-to-twelve while youth are in their sleeping quarters. During the annual compliance review, youth were observed during recreation, breaks, education, recreation, and while in sleeping rooms. Observations determined staff were actively supervising youth within ratio requirements. During an interview, each of the three staff were able to identify how many youth were under their supervision without having to count the youth. Youth were accompanied by staff at all times during the annual compliance review. At no time youth were observed to be roaming freely without a staff. A review of the program's activity schedule found a full schedule of activities were planned for youth each day.

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

The program has a written policy and procedures addressing the behavior management system (BMS), known as iChoose. The policy includes all required elements including a four-to-one ratio of positive-to-negative consequences. The BMS does not include increasing a youth's length of stay, denial of basic rights, group punishment, or punishment of youth by other youth. The BMS is extensively described in the youth and staff handbooks including expectations, incentives, and consequences for youth behavior. A review of five youth records determined each youth orientation included a review of the BMS. Documentation in all records indicated the youth received a copy of the youth handbook. A review of the program's BMS policy determined there is an agreement between the program and the school related to the BMS. The program has been renovating the hallways and mods, to include new paint and designs on the walls. The facility administrator is arranging for a new sign to be made for the BMS, which will be posted as soon as possible.

The policy states consequences are in direct relation to the severity or seriousness of inappropriate behavior. Youth can receive level suspensions between one and twenty-one days, depending on the severity of the behavior. Two of the five interviewed youth reported consequences can include up to a twenty-one day level suspension. Two youth revealed youth will receive an early bedtime for minor infractions. Three youth reported points will be taken away as a consequence. Three youth revealed more days will be added to a youth's stay at the program. The five youth reported rewards include canteen, monthly incentives, awards, meals

from outside the program. Each of the five interviewed staff explained the BMS accurately. Staff reported rewards for youth include nightly incentives, later bedtimes, snacks, video games, canteen, and games. Two of the five interviewed staff revealed items cannot be taken away from the youth as a consequence. The remaining three staff reported youth radios will be taken away if youth are on a level suspension, no television privileges, and early bedtimes. The facility administrator reported the BMS allows youth to know when they are doing well and what behaviors need improvement. Staff utilize daily point sheets to monitor how well youth are doing in the program. Youth can earn zero, five, or ten points for exhibiting pro-social behaviors during activities. Point sheets are totaled daily, as well as weekly. Youth who earn all their points for the day, or "make their day," are rewarded with nightly privileges. Youth who earned the required weekly points based on their current level will earn weekly privileges.

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 written policy and procedures regarding staff receiving feedback on the implementation of the behavior management system (BMS). A review of applicable position descriptions included the application of the BMS, as required. Four of the five interviewed staff reported receiving feedback on the implementation of the BMS at the beginning and end of each shift and during briefings. The remaining staff was not sure when feedback was provided to staff. The program's contract ensured all required parties were involved in the development, implementation, and on-going maintenance of the BMS. The BMS includes a process requiring staff to explain to the youth the reason for any consequences imposed, allows for the youth to be provided a chance to explain their behavior, discussions between the staff and youth regarding the impact of the youth's behaviors on others, reasonable reparations for harm caused to others, and alternative acceptable behaviors. Youth are given the opportunity to complete restorative justice activities to make amends for their behaviors. Youth who received ten or more days of level suspension may complete a restorative justice activity to reduce the suspension by three days.

All five interviewed staff reported youth are informed of consequences received and are provided an opportunity to explain their behavior. Major rule violations result in the youth receiving a Problem Behavior Report (PBR). The PBR is submitted to the supervisor and if deemed appropriate, the report is forwarded to the Behavior Review Team (BRT). This team consists of the facility administrator (FA), clinical director, the youth's therapist, and case manager. The BRT reviews the PBRs daily and applies consequences, as needed.

Five reviewed staff records confirmed each of the staff completed training on the BMS. Staff were trained on the jointly combined BMS plan which includes the utilization of the BMS during education classes. Education staff have not been trained on the use of BMS during school. The FA reported the educational staff were hired on August 31, 2020 and training on the BMS has

been scheduled for December 7, 2020. The five interviewed youth reported there are between four and six levels of the BMS. Youth reported the higher the level, the closer youth are going home. All of the youth revealed youth are never allowed to punish other youth and staff are consistent in the use of rewards. Three youth rated the BMS as "good," one rated it as "fair," and the remaining youth rated the BMS as "very poor." The FA indicated the program ensures rewards outnumber consequences by utilizing a four-to-one ratio of positive-to-negative consequences. Staff reward youth with "Gotchas", points, awards, and nightly and weekly incentives. The FA further revealed the treatment team monitors consequences. Staff are monitored on the implementation of the BMS during monthly team meetings, shift supervisor meetings, and evaluations.

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

The program has seventy-one cameras in which all were operational at the time of the annual compliance review. Video footage is stored for sixty days. Video recordings were reviewed for five nights on two separate hallways across all three shifts, including recordings of checks for youth who did not earn enough points throughout the day and had early bedtimes. Video confirmed staff completed checks on youth throughout the night by stopping and looking in each window every eight minutes. Written documentation compared to the video recordings confirmed checks were documented in real time and initialed by the staff completing the check. Three of the five interviewed staff reported checks are completed every ten-minutes when youth are placed in their rooms. The two remaining staff reported checks are completed every eight minutes.

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

The program has a written policy and procedures regarding youth census, counts, and tracking. The program utilizes one logbook which is maintained in master control. A review of the logbook determined counts were conducted at the beginning of each shift, after each outdoor activity,

and during emergency situations. Logbooks reflected the daily census each day, scheduled and unscheduled counts, youth movements, admissions, releases, transfers, and youth away from the program, as required. All five interviewed staff reported youth counts are conducted at least once an hour. Staff revealed when there is a discrepancy in the count, all movement stops, and recounts are conducted until reconciled. Each of the staff accurately reported the number of youths in the census.

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

The program utilizes one logbook for the program which is maintained in master control. A review of logbooks for the six months prior to the annual compliance review found the logbooks were bound with numbered pages and all entries were made in ink with no erasures or white-out areas. Each of the entries documented the dates and times of the events, names of staff and youth involved, brief descriptions of the events, and the names and signatures of the staff making the entries. Most errors were struck through with a single line and dated and initialed by the staff correcting the error. There were three instances in which minor errors were struck through; however, no initials were documented from the staff correcting the error. The logbooks documented all required events, incidents, and activities, including emergency situations, population counts, perimeter security checks, transports, admissions, releases, and reports to the Central Communications Center and Florida Abuse Hotline. The program utilizes shift reports which reflect summaries of the events, incidents, and activities throughout each shift. Documentation confirmed shift supervisors verbally briefed the incoming staff regarding the two previous shifts. All incoming staff signed and dated the shift reports for the previous shifts acknowledging their review of the shift report, as required.

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

The program has a written policy and procedures addressing key assignments, usage, the inventory and tracking of keys, secure storage, missing or lost keys, and the reporting and replacement of lost or damaged keys. Observations during the annual compliance review found staff received facility keys in exchange for personal keys. Chits were given to visitors which corresponded to the numbered hook the personal keys were hung on. All keys were maintained on a tamper-proof, sealed number key ring. Each of the key tags documented the number of keys maintained on the ring. A review of the key inventory determined the inventory corresponded to the keys in use. The inventory sheets included the assignment of keys as well as any radios distributed for transports. The inventory documented staff names, initials, the types of keys assigned, times keys and radios were signed in and out, chit numbers (if

applicable), and initials of the staff distributing or collecting keys or radios. Staff are assigned keys based on position. Restricted keys for the facility administrator (FA), assistant FAs, unit managers, and clinical directors are stored in a coded lock box in master control. Unrestricted keys are stored in a lock box in master control.

Observations during the first two days of the annual compliance review found the lock box was not consistently secured when not in use. This issue was quickly corrected by administration throughout the remainder of the annual compliance review. Three staff were questioned of the keys on their person to compare to the inventory. Each of the staff keys matched the inventory, as required. An interview with the master control operator found their personal keys were placed in a purse behind the desk, rather than secured in the lock box. This was addressed with administration and corrected. There were no incidents of lost or missing keys in the six months prior to the annual compliance review. The FA reported when a key is lost or damaged, a maintenance request is completed and a replacement is made usually within one day. All five interviewed staff were able to explain the key control process.

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

The program has a written policy and procedures regarding contraband which contains all required elements. The program's policy defines all items and materials considered to be contraband including personal cell phones, electronic or vaporless cigarettes, and smart watches. Upon admission, each youth receives a handbook which outlines all items considered contraband. The youth handbook states any youth found with contraband will receive consequences to include three days of level suspension. Contraband found is discarded, returned to the original owner, mailed to the youth's home, or stored and returned to the youth upon their release from the program. The program conducts searches of the physical plant, facility grounds, youth, and incoming and outgoing mail. A review of facility logbooks and search reports determined the program completes searches at least once a week. The search reports documented the times, dates, and locations of the searches, as well as any contraband found. The facility administrator (FA) reported any suspicions of a youth, staff, or visitor having contraband is dealt with immediately to ensure the safety and security of the program. All discovered contraband shall be destroyed, disposed of, and sent to the youth's home or retained as evidence to submit to law enforcement as indicated for illegal contraband. The FA

further revealed possession of contraband presumed illegal shall require notification to law enforcement, establishment of chain of custody to include documenting when, where, and who discovered. If the nature of the contraband requires notification to law enforcement or filing criminal charges, the contraband shall be considered evidence and must not be altered.

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 were observed being searched before movements, before and after transports, before admission, and before meetings with case managers. Youth were treated with dignity and respect and searched by a staff of the same gender. Observations confirmed the searches were thorough and conducted according to the Protective Action Response training manual. A review of the visitation log documented youth who were searched prior to and after visitation. All five interviewed youth reported searches are conducted before and after every movement. Two youth revealed searches are conducted when returning from off-site, three revealed after outdoor activities, one youth revealed after visitation, and one youth reported after meals. Five interviewed staff reported youth searches are conducted before every movement.

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

The program has two vans which are utilized for the transportation of youth. Reviewed documentation confirmed each of the vans received annual inspections, as required. Maintenance records were maintained for each van. Inspections of both vans found each contained a fire extinguisher, approved first aid kit, seat belt cutter, window punch, and the appropriate number of seat belts. Observations found each van was secured when not in use, youth are not attached to any part of the vehicle by any means other than a seat belt, and the doors to the youth areas cannot be opened from the inside. One van is a secured vehicle with a safety screen, as required. A check of seven personal and program vehicles found all but one was secured when not in use. The remaining car was secured immediately upon notification.

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

The program has a written policy and procedures regarding youth transportation which contains all required elements. Staff are provided a radio and/or cell phone during transports. A regional juvenile detention center is located across the street from the program. When staff pick up youth from the detention center prior to admission, staff are provided a radio. If transports are further from the detention center, staff are provided a cell phone. The program requires a staff-to-youth ratio of one-to-five during all transports. If less than five youth are transported, at least two staff

are required during the transport. Observations of a youth transport from the detention center to the program found staff searched the vehicle prior to transport. Two staff transported the youth, as required with one staff in the back seat with the youth. Both staff were the same gender as the youth. Both staff and the youth wore a seat belt during the transport. The youth was never left unsupervised in the vehicle.

All staff responsible for youth transports had a current driver's license. All five interviewed youth reported never seeing anyone place contraband in a transport vehicle and felt staff drive vehicles safely. Each of the five interviewed staff reported cell phones are provided during transports. Four of the five staff reported radios are also provided. All staff indicated first aid kits, a knife for life, suicide kit, window punch, seat belt cutter, and fire extinguisher are stored in the transport vehicles. Staff reported no staff is allowed to transport youth in personal vehicles and vehicles are searched for contraband prior to and after transports. Three of the five staff reported if an emergency response was required during a transport, they would notify the facility administrator. Two staff indicated they would call 9-1-1 and one indicated they would notify the youth's parent/guardian. The remaining two staff were unsure how to answer the question. Three of the five staff reported staff-to-youth ratios during transport is two-to-one, one reported two-to-five, and the remaining staff indicated one-to-five.

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

The program has a written policy and procedures regarding weekly safety and security audits. The policy indicates the facility administrator (FA) ensures the audits are completed weekly and the assistant FAs or designees complete the audits. The weekly audits are reviewed with the FA and administration during daily meetings and any emergent issues are addressed and reviewed immediately. The program has an internal system to verify deficiencies are corrected and existing systems are improved or new systems are put in place as needed, to maintain compliance. Deficiencies are followed-up with and verified by the assistant FAs and discussed during daily meetings. A review of weekly safety and security audits for six months prior to the annual compliance review determined audits were completed every seven days, as required.

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 written policy and procedures addressing the issuance, inventory, and control of equipment and tools. All tools used by maintenance staff are securely stored in a locked office, inaccessible to youth. All kitchen knives are stored in a locked box in the kitchen. All tools were marked for easy identification. The program prohibits machetes, bowie knives, and other long-blade knives. A review of sign-in sheets confirmed tools were signed-in and signed-out as the tools were utilized. Inventories of tools with sharp or pointed edges were completed at the beginning of each day. Monthly inventories were completed for tools without sharp edges or points. A review of the tool inventory compared to tools stored in the office found eleven of the twelve tools reviewed were documented. The inventory sheet was missing one nut screw. Any dysfunctional tools are disposed of or replaced, as needed. Maintenance staff indicated if a tool is no longer functional, a maintenance form is completed which documents what tools were replaced or removed from inventory. If any tools are missing or lost, all movement in the facility is stopped, the facility is searched and if the tool is not found, the

Central Communications Center is notified within two hours. A review of five staff records determined each staff completed training on the intended and safe use of tools. All five interviewed staff reported youth are allowed to use mops and brooms. One staff indicated youth also use scrub brushes.

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

The program has a written policy and procedures regarding youth tool handling and supervision. The policy includes procedures for issuing tools to youth and staff, including an assessment to determine a youth's risk to their selves and others. The staff-to-youth ratio during activities involving tools is one-to-five. The program allows youth with approved reassessments to utilize Class A tools during gardening and lawn maintenance projects. A review of five youth records determined each youth received a reassessment prior to utilizing any tools. All five interviewed youth reported using mops and brooms. Two youth indicated they have used rakes and scrub brushes.

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

The program has a written policy and procedures regarding outside contractors. The program's contraband policy states approval shall not be extended to vendors to bring personal cell phones and/or equipment or electronic devices capable of taking pictures and/or audio/video recordings including smart watches in the secure area of the facility. Six contractor agreement forms were reviewed. Each form documented the sign-in and sign-out times of the contractor and inventories of tools upon arrival and departure. During work projects, youth were restricted from the area.

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.	

Fire, safety, and evacuation drills were reviewed for the six months prior to the annual compliance review. Unannounced fire drills were completed monthly on each shift, as required. Documentation for each of the drills included all required elements. Nine drills were conducted for other emergency situations to include escapes, weather, and riots; however, eight of the nine drills were conducted during the second shift. The remaining drill was completed on the first shift. Documentation for each of the drills included the types of drills, dates, times, participants, brief scenarios, as well as findings and recommendations. Five interviewed youth knew what to do in case of a fire. Fire evacuation routes and egress plans were posted throughout the facility. All fire extinguishers were inspected annually. Two youth reported fire drills are conducted weekly, one youth reported twice a month, and one youth reported fire drills are held every three weeks. The remaining youth did not confirm how often drills were conducted. All five interviewed staff participated in fire drills during the previous twelve months. Three staff reported participating in weather drills and one staff also participated in chemical spill and escape drills.

The facility administrator reported fire and medical drills are conducted monthly and suicide and disaster drills are held quarterly.

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

The program has a written policy and procedures addressing the disaster plan and Continuity of Operations Plan (COOP). The COOP was reviewed and updated by the program on February 18, 2020 and approved by the Department's regional director on March 5, 2020. Copies of the COOP are located in master control and the facility administrator's (FA) office. The program's disaster plan and COOP are combined into one plan and includes all required elements. The FA indicated the disaster/COOP is available to staff at all times in master control. Observations found the program has a supply of equipment and supplies required for continuous operation and services during emergency or disaster situations. Supplies included bottled water, sports drinks, non-perishable food items, and hard copy records of each youth's identifying information. Five hard-copy records were reviewed and each contained all required information, with two exceptions. Two records were missing contact information for the youth's committing judge and State Attorney's Office; however, this information was added to the records during the annual compliance review.

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

The program has a written policy and procedures regarding the storage and inventory of flammable, poisonous, and toxic items and materials. All flammable, poisonous, and toxic items are stored in a locked shed located in the sally port, in a locked shed behind the facility, or in a secured closet in the kitchen. Inventories were maintained for all flammable, poisonous, and toxic items. A review of the inventory compared to the items within the program found no discrepancies. The program identifies two maintenance staff as the only staff authorized to handle flammable, poisonous, or toxic items. Safety Data Sheets (SDS) were found for each item and were stored in the same area where the items were physically located.

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

The program has a policy and procedures addressing youth handling and supervision of flammable, poisonous, and toxic items and materials, which indicates youth are prohibited from handling these items and materials. The program stores all flammable, poisonous, and toxic items in secured locations outside of the facility or in the kitchen, inaccessible to youth. No youth were observed handling any flammable, poisonous, or toxic items or materials. A review of the program's Preventative Maintenance Checklists determined checklists were completed weekly, monthly, and annually as required. All five interviewed youth reported they do not use any chemicals or cleaning products. One youth indicated using paint; however, the youth is not given the paint.

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

The program has a written policy and procedures regarding the disposal of flammable, toxic, caustic, and poisonous items. Maintenance staff are responsible for the disposal of all flammable, toxic, caustic, and poisonous items. The program reported all chemicals are used in their entirety; however, if additional items require disposal, the hazardous waste contractor is contacted. Liquid waste other than grease, is disposed of through in plumbing drains. Grease is placed in a separate container. Procedures indicate all hazardous waste and toxic substances are disposed of in accordance with the Occupational Safety and Health Administration. The facility administrator reported all hazardous chemicals are disposed of within the parameters of state, local, and federal laws. All grease is placed in the grease trap located in the sally port and all chemicals are disposed of through the drains located in the utility closet.

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

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

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

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

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

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

The program does not participate in any water-related activities; therefor, this indicator rates as non-applicable.

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures regarding visitation and communication. The visitation schedule is posted in the lobby. Visitation hours are held every Saturday and Sunday from 1:00 p.m. to 4:00 p.m. Alternative visitation arrangements may be arranged with approval from the facility administrator. Case managers are responsible for maintaining mail and telephone logs for youth under their supervision. A review of telephone logs confirmed youth were permitted at least one ten-minute telephone call each week with approved family members. Youth can “buy” additional telephone calls each week with points earned through the behavior management system. Youth are given the opportunity to send an unlimited amount of mail correspondence with approved family members. A review of mail logs documented each piece of incoming and outgoing mail was searched, as required. During the COVID-19 pandemic, visitors were not permitted to enter the facility; therefore, visitation was cancelled. Due to the cancellation, staff arranged for youth to video conference with approved family

members utilizing FaceTime, Zoom, and Duo. Face to face visitation resumed on October 16, 2020. A review of the visitation logbook documented sign-in and sign-out times of family members. Copies of visitors' identification cards were maintained in the visitation logbook. All five interviewed youth reported they are able to send letters and call their parent/guardian while in the program.

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

The program has a written policy and procedures regarding controlled observation. The program has controlled observation rooms which meet all requirements including a metal door with a shatter-resistant window, recessed lighting fixtures, and no electrical outlets. The program had seven instances of controlled observation during the annual compliance review period, of which five were reviewed. A review of the five youth controlled observation reports confirmed both the youth and rooms were searched prior to placing the youth in controlled observation.

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

The program had seven instances of controlled observation (CO) during the annual compliance review period of which five were reviewed. Each of the reports documented all required elements including approval by supervisory staff to place the youth on CO, reasons for placement, and explanations to youth regarding the reasons for placement and expected behavior for removal. Four of the five reviewed reports documented a health status checklist was completed by a healthcare professional. The remaining report was missing the second page of the checklist; therefore, it could not be determined who completed the checklist. Two of the five youth were placed in CO for more than two hours. Documentation confirmed the facility administrator or designee approved the continued placement at least every two hours, as required. None of the five interviewed youth had been placed in CO while at the program.

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

The program had seven instances of controlled observation (CO) during the annual compliance review period, of which five were reviewed. Each of the five reviewed CO reports documented the staff making the placement completed the first page of the CO report and submitted the report to a supervisor. Documentation confirmed safety checks were completed for each youth every fifteen minutes. All safety checks and observations were completed utilizing the Controlled Observation Safety Checks form, as required. Prior to each youth's removal from CO, documentation confirmed the facility administrator (FA) or designee provided written approval for the youth's release from CO. All CO reports, health status checklists, and safety checks were maintained in an administrative file, as well as the youth's record. Each of the CO

reports documented the FA's review and approval of the placement on CO within fourteen days of the youth's release from CO, as required.