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 Road
Crestview, Florida 32539

Review Date(s): December 3-6, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Ken Phillips, Office of Program Accountability, Lead Reviewer (Standard One)
Lea Herring, Office of Program Accountability, Regional Monitor (Standard Two)
Randy Hardin, Juvenile Unit Specialized Treatment, Clinical Coordinator (Standard Three)
Shyron Johnson, DOVE Academy, Assistant Program Director, (Standard Five)
Patrick McKinstry, Office of Program Accountability, Regional Monitor (Standard Four)

Program Name: Crestview Youth Academy - Nonsecure	MQI Program Code: 1441
Provider Name: Youth Opportunity Investments, LLC.	Contract Number: 10210
Location: Okaloosa County / Circuit 1	Number of Beds: 24
Review Date(s): December 3-6, 2019	Lead Reviewer Code: 145

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Crestview Youth Academy – Nonsecure program is a twenty-four bed program, for thirteen to eighteen year old males, located in Crestview, Florida. The program is operated by Youth Opportunity Investments, LLC., through a contract with the Department. The program provides both Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS). The program also provides developmental disability treatment services through evidenced-based delinquency interventions and the Impact of Crime curricula, which enhances Restorative Justice Awareness for youth. Crestview Youth Academy - Secure substance abuse program is also located within the same building and under the same provider. These populations, however do not interact with one another. Additional services provided include Life Skills Training, Skillstreaming the Adolescent, and Male Healthy Relationships, which is the gender-responsive intervention designed to target the program's male population. Program administration is comprised of a facility administrator and two assistant facility administrators. Crestview Youth Academy has a total of four case managers and six therapists, all who are supervised directly by the clinical director. Two therapists and two case managers are assigned to the non-secure component of the program. The program also has one transitional case manager who works both the non-secure and secure component sides. The program also has a contracted psychiatrist who provides psychiatric services bi-weekly. Other key positions include a recreational therapist, a registered nurse who serves as the health services administrator, and two other registered nurses. Medical services are offered Saturday through Friday. A contracted medical doctor serves as the designated health authority. Educational services are provided through an agreement with the Okaloosa County School Board. Teachers are employed through the school district and provide classes Monday through Friday. At the time of the annual compliance review, the program's facility administrator reported the following vacancies: three youth care workers, one therapist, and two shift supervisors.

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.	

A total of nineteen staff personnel records were reviewed for initial background screening. Seventeen of nineteen received a completed background screening prior to the staff's hire date. The remaining two staff background screening was completed and determined eligible after the staff were hired, but only for training and orientation purposes, thus not allowing for staff contact with youth or youth records during this time. All staff records included the Diana Screening as the pre-employment assessment tool administered for direct care applicants. Passing scores were also available within all staff records. Evidence was also available confirming criminal history report information, Central Communications Center information, and Staff Verification System module was reviewed for all nineteen staff records. The program reported having had no volunteers or interns who required initial background screening this review period. The program completed and submitted the Annual Affidavit of Compliance with Level 2 Screening Standards on January 10, 2019. Teachers at the program are paid by the County School Board and Department of Education, and receive annual screening as required. The School Board also submitted the Annual Affidavit of Compliance with Level 2 Screening Standards on January 10, 2019.

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 staff roster and initial hire dates found no staff required a five-year re-screening during the annual compliance review period. The program has a written policy and procedures in place to address initial background screening and five-year re-screening.

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

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

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

The program has a written policy and procedures outlining provisions of an abuse free environment. The policy indicates all staff who have knowledge, or reasonable cause to suspect a child is being abused or neglected shall report the information to the Florida Abuse Hotline or Central Communications Center (CCC). Staff shall provide unhindered access to report alleged abuse. The shift supervisor will be notified in the event a youth chooses to make an abuse call. The supervisor will assist the youth in placing the call, dialing the number, and recording the date and time of the call. The youth will be allowed to communicate with the Florida Abuse Hotline operator, while the staff maintains sight of the youth, but remains in an area which allows for the youth to freely and confidentially report. Observations made during the annual compliance review found postings of emergency numbers for the Florida Abuse Hotline and the CCC. In addition, each youth receives a youth handbook upon admission. A review of the handbook found the emergency numbers included within. Staff adhere to a Code of Conduct as evident of five personnel records reviewed. Each of the five staff signed for the employee handbook which outlines their Standards of Conduct. The program completed and submitted the annual Trauma Responsive and Care Environment (TRACE) self-assessment as required. The program reported having had no incidents related to physical, psychological, emotional abuse since the last annual compliance review. Five of five staff training records reviewed found each staff received Child Abuse Reporting training as part of their annual training requirements. The facility administrator was interviewed, and stated Crestview Youth Academy's incident reporting process is to contact an administrator as soon as possible with details of the incident. The facility administrator is made aware of the incident. Administration will then determine if it is a reportable incident based on the Florida Administrative Rule. The call has to be placed within two hours of gaining knowledge. If it is a staff related issue, requirements are for them to be removed from all youth contact pending the results of the investigation. The master control log will capture documentation and contacts made for the incident report. Five interviewed staff were able to summarize the abuse reporting procedures. None of the five staff stated they have

heard another staff deny a youth the opportunity to make an abuse report. None stated they have heard or observed a co-worker use profanity or make threats when speaking with youth. Five interviewed youth all reported feeling safe at the program. None of the five youth reported ever having to contact the Florida Abuse Hotline or CCC. All youth stated staff are respectful when talking with them and other youth. Four of five youth reported they have never heard staff use curse words when speaking with them. One youth stated he has heard staff curse once when he got mad.

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 reports having no incidents of physical, psychological, or emotional abuse since the last annual compliance review; therefore, this indicator will be rated 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.	

A review of the Department's Juvenile Justice Information System (JJIS) found the program had three incidents reported to the Central Communication Center (CCC) for the scope of the annual compliance review. This is a decrease from the previous annual compliance review. A review of the internal grievances and incident reports provided found no other incidents required to be reported to the CCC. For the three incidents reported, all were reported with the two-hour timeframe as required and were documented in the master control log. The facility administrator was interviewed, and stated Crestview Youth Academy's incident reporting process is to contact an administrator as soon as possible with details of the incident. The facility administrator is made aware of the incident. Administration will then determine if it is a reportable incident based on the Florida Administrative Rule. The call has to be placed within two hours of gaining knowledge. If it is a staff related issue, requirements are for them to be removed from all youth contact pending the results of the investigation. The master control log will capture documentation and contacts made for the incident report.

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

The program has a Protective Action Response (PAR) plan which was submitted to and approved by the Department on January 22, 2019. Based on review of PAR information provided and documentation, the program has experienced a decrease in the total number of PAR incidents for this annual compliance review period. The program's current PAR Rate is .49, which is below the Statewide PAR Rate of 2.35. The program had a total of one PAR incident

this review period. A review of the incident and documentation found the report was completed by the end of the staff member's workday and included statements from all staff involved. The incident did not indicate any injuries to staff or youth and did not require a Mechanical Restraint Supervision Log. The PAR incident was documented as reviewed by a PAR certified instructor. The report information as reviewed by the facility administrator within seventy-two hours of the incident as required. A copy of the PAR report was placed in a centralized file within forty-eight hours of being signed by the facility administrator. The facility administrator was interviewed, and stated Crestview Youth Academy monitors PAR incidents by discussing with staff through Monthly All Team Meetings, shift debriefing, and as needed Coaching Sessions. If there is a youth who is continuously being involved in physical intervention administration provides feedback. The treatment team makes all attempts to help youth with tools on how to be successful in the program as in relates to the youth's treatment.

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

The program submitted, in writing, a list of pre-service training to the Department's Office of Staff Development and Training which includes course names, descriptions, objectives, and training hours for any instructor-led training. This information was submitted by the program January 19, 2019. It was signed by the Department on February 7, 2019. Five staff training records were reviewed for pre-service training requirements. Four of five staff had over the 120 minimum required training hours within their first 180 days of employment. The remaining one staff had a total of 118.5 hours but was still within their 180 days. All five staff had training for cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and Protective Action Response (PAR). All had received professionalism and ethics training, suicide prevention/intervention, emergency procedures, child abuse reporting, active shooter training, and Prison Rape Elimination Act (PREA). Other contractually required pre-service trainings included stress management, behavioral modification, and restorative justice. Each of the five training records included evidence for these trainings, with the exception of one staff who did not have restorative justice training. The program documents all trainings within the Department's Learning Management System (SkillPro). All instructors were qualified to deliver training provided.

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

The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training which includes course names, descriptions, objectives, and training hours for any instructor-led training. This information was submitted by the program on January 19, 2019. It was signed by the Department on February 7, 2019.The program also maintains an annual in-service training calendar, which is updated as changes occur. All instructors were qualified to administer training provided. An interview with the facility administrator found only youth care workers are counted within the staff to youth ratio. Unit managers and supervisors

may be counted only if they are working outside their normal job duties. A review of the staff roster and hire dates found one staff member eligible for a review of in-service training requirements. The previous annual compliance review was conducted within the 2019 calendar year, therefore the remaining staff indicated on the roster had been selected for the previous annual compliance review, or they have not had sufficient time at the program to be eligible for completing 2018 in-service training requirements. The last annual compliance review did not reflect any deficiencies in in-service training for the program. The review included a total of five staff records reviewed, including two supervisory staff. The one eligible staff member's training record was reviewed. All training was documented within the Department's Learning Management System (SkillPro). The staff had received 162 hours of annual in-service training for calendar year 2018. Completion of training included cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and Protective Action Response (PAR). All had received professionalism and ethics training, emergency procedures, child abuse reporting, and active shooter training. The staff had also completed suicide prevention/intervention training to include two hours within SkillPro, and four hours of instructor-led training. Other contractually required trainings for the staff were completed, to include the Massachusetts Youth Screening Instrument (MAYSI-2) and Residential Positive Achievement Change Tool (R-PACT).

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 addressing the grievance process. The policy includes the following phases: Informal, Formal, and Appeal. The policy also indicates any youth requesting to file a grievance be given the proper forms, assistance, and instructions on the preparation and submission of a grievance. The policy also includes staff training requirements for the grievance process. A review of five staff training records found all staff received grievance response training as required. The youth handbook is provided to each youth upon admission, and also contains the grievance completion instructions. For the Formal, or second phase of the grievance process, the supervisor must provide a response within two days of receiving the grievance. Should the grievance reach the Appeal Phase, it would then require a response from the facility administrator within twenty-four hours of receiving the grievance. In addition to grievance's youth are provided with copies of Request to Speak forms. These forms are located alongside the grievance in designated boxes on the living units. A locked drop box was provided for youth to place their completed forms. The assistant facility administrator assigned to the living unit is responsible for checking these boxes daily. A review of grievances maintained by the program found only one grievance for the scope of the annual compliance review. The grievance was reviewed and found to be resolved at the Formal Phase, and within the required timeframe. The facility administrator was interviewed and was able to summarize the grievance process. Five staff and five youth were also interviewed and able to explain the grievance process. All five youth also stated they are able to ask staff for assistance if needed when completing a grievance.

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

Training records were reviewed for the program's six therapists and four case managers. All ten staff had the required level of education, training, and required experience working with juveniles. A review of the provider's contractual agreement of required therapeutic services was completed. The clinical director was interviewed and indicated the program uses evidenced based services, and interventions which are promising practices with demonstrative effectiveness. The program conducts groups seven days a week. Groups provided include Life Skills Training, Skillstreaming the Adolescent, Male Healthy Relationships, and Impact of Crime (IOC). The program's activity schedule was reviewed and determined the program was providing structured, planned programming at least sixty-percent of the youth's awake hours. A review of group sign-in sheets was completed for all groups to confirm the groups were being delivered as indicated on the activity schedule. The facility administrator was interviewed and stated therapists and case managers who have credentials are the ones selected to facilitate these groups with youth. Five youth records were reviewed to determine whether delinquency interventions were being delivered. All five youth were currently involved in interventions addressing an identified priority need, which was also identified in each individualized performance plan.

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 conducts therapeutic groups seven days a week. Groups provided, and indicated within the provider's contractual agreement for life and social skills training provided to youth include Life Skills Training and Skillstreaming the Adolescent. The program's activity schedule was reviewed and determined the program was providing structured, planned programming at least sixty-percent of the youth's awake hours. Youth receive life and social skills intervention services specifically addressing areas such as communication skills, relationships, conflict resolution, anger management, and problem-solving skills. The clinical director reported Life Skills Training and Skillstreaming the Adolescent groups were primarily focused on life and social skills training provided for youth. Five youth records reviewed found evidence all five youth were involved in a therapeutic group focused on enhancing life skills training. Group sign-in sheets and curriculums were reviewed to confirm the practice. Groups were conducted as outlined on the group and activity schedules. The clinical director stated youth involved in the groups will often conduct role-playing scenarios with life situations, take notes, and give feedback to others. Five interviewed youth stated they participate in groups at the program, and were able to explain things they have learned in these groups, such as taking responsibility for their own actions, helping others, listening and thinking.

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

The provider's contractual agreement indicates the Impact of Crime Curriculum (IOC) is provided to youth to enhance Restorative Justice Awareness for youth, assist youth in taking responsibility for their actions, and teaching youth about the impact their crimes have on victims, their families, and communities. The clinical director was interviewed and stated the program has four case managers who are responsible for facilitating the IOC curriculum. A review of these four staff training records found each has received training to facilitate the groups. The program's activity schedule also determines when groups are held. The program conducts these groups Mondays, Thursdays, and Fridays. Groups sign-in sheets were also reviewed to confirm the practice. Five youth case records were reviewed and found all youth were currently participating in the IOC groups. The facility administrator was interviewed and reported the following types of restorative justice groups and activities are provided for youth: Impact of Crime Curriculum; Assistance for Life Pointe church preparation for their Easter celebration for the community, youth participated in clean up, organizing furniture, and waxing floors during the summer for Davidson Middle School; youth worked cleaning up the stadium after home football games; provided carwashes for the community for free and took donations. All donations were used to purchase book bags, and school supplies.

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.	

Based on a review of the provider's contractual agreement, the program is required to provide the curriculum Male Healthy Relationships/Young Men's Work for gender-specific programming. According to the clinical director, the groups are split into two: Male Healthy Relationships and Teen Healthy Relationships. The groups are held three times each week. The program's activity schedule includes the groups and gender-specific programming. The program designs its services based on the common characteristics of its male population. A review of group agendas and sign-in sheets was completed to confirm the groups are held regularly as scheduled. All groups are facilitated by master's-level therapists, according to the clinical director. The facility administrator was interviewed and stated the program addresses the needs of a targeted gender group through the Male Healthy Relationships curriculum and gender-specific training for staff. A review of five staff training records found all have been trained in gender-specific programming as part of their annual training requirement.

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 entitled internal and Department Juvenile Justice Information System (JJIS) Alert System, which determines how alerts are identified, documented, updated, and communicated to staff. A review of the alerts was completed and found no issues with identified alerts for youth placed on the alert system. The program maintains an internal alerts system for all security alerts, medical, and dietary alerts. A master alert board is posted in the staff conference room which displays all open alerts for youth. Youth with dietary concerns and food allergies and restrictions are posted on an internal alert board also located in the kitchen area for dietary staff to view. All youth JJIS alerts are reflected in the internal alert system. Five interviewed staff all reported they are notified of youth alerts through shift briefings and the master alert board. A review of shift briefing reports found evidence alert information is documented accordingly. The facility administrator was interviewed and stated each department head is responsible for inputting and closing any information in JJIS. The alert board is located in the conference room. Management reviews alerts daily and/or as information changes. Each special alert has a different color assigned. The facility administrator further stated healthcare staff review alerts through morning management meetings and print out alert information daily. Five youth were selected to review JJIS and internal alert information. A total of sixteen alerts were reviewed for these youth. All alerts were entered by the required staff members. All were verified prior to entering into JJIS. All applicable alerts were documented in the program's logbook. Three of the sixteen alerts had alert notes which were entered late. One was eight days, one was two weeks, and one was entered three weeks late. An alert note for asthma was completed July 9, 2019, but no note information was given. All youth had the appropriate medical grade given.

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

The program separates youth records into separate files: an individual healthcare record and an individual management record. Mental health records are kept in a separate file system. A review of five individual management records found they were all organized as required, containing a file tab which included the name of the youth, Department's identification number, date of birth, county of residence, and committing offense. Sections were divided to include legal information, chronological information, correspondence, case management, treatment team activities, and a miscellaneous section. All records were labeled confidential and were

secured behind two locks. The program identifies cabinets used to store these records as confidential.

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

The program provides formal processes to promote constructive input by youth. In addition to grievances provided by the program, the youth are given Request to Speak forms which give them the opportunity to speak with a supervisor, teacher, therapist, or member of administration with any concerns they may have. The forms are provided in the living units and have a locked drop box located beside them. The boxes are checked daily by the assistant facility administrator assigned to the living unit. The program has a written policy and procedures outlining the channels of communication for youth, which discusses the community advisory board, youth student council and town house meetings. The youth student council meets biweekly and is facilitated by the facility administrator. Youth are appointed to the council by student representatives. Town house meetings are done weekly and facilitated by the unit managers. These are also reviewed by the facility administrator. Observations were made of sign-in sheets, minutes, and agendas to confirm the groups are being held as required. In addition to the meetings, the program administers youth and parent/guardian surveys monthly to randomly selected youth. These are completed on-line and are included in a key performance indicator (KPI) report. The information is forwarded to, and reviewed by, the provider's corporate office. These surveys include family, staff, and youth, and a report is generated and sent back to the facility administrator, who then completes any corrective action if needed. Examples of these surveys were observed to document the consistency with completing the information. Five interviewed youth all reported they have a student council as an avenue to allow youth the ability to provide input into program operations. The facility administrator was interviewed and stated the system in place for youth to provide input are the Request to Speak forms, town house meetings, and advisory board meetings.

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

The program holds community advisory board meetings quarterly as evident of agendas, sign-in sheets, and meeting minutes reviewed. The program held a meeting in May, August, and November of 2019. The program solicits advisory board participation from the following members: a representative from law enforcement, the judiciary, community partners, business community, school board, faith community, victim advocate, and a parent/guardian whose child was previously involved in the juvenile justice system. A telephone interview with a randomly selected advisory board member was completed to confirm their participation. The member stated she meets as scheduled and is notified through email. She stated she has enjoyed her participation with the program and they meet to discuss ways to assist youth in the program. The facility administrator was interviewed concerning the advisory board. He stated the board provides suggestions and ways of how to assist the program and the youth. The board meets quarterly as required, and times varies based on member's schedules.

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

The program has a written policy and procedures which details the channels of communication within the facility. The program administers youth and parent/guardian surveys monthly to randomly selected youth. These are done on-line and are included in a key performance indicator (KPI) report. The information is forwarded to, and reviewed by, the provider's corporate office. These surveys include family, staff, and youth, and a report is generated and sent back to the facility administrator, who then completes any corrective action if needed. Examples of these surveys were observed to document the consistency with completing the information. According to an interview with the facility administrator, the Comprehensive Accountability Report (CAR) is furnished annually by the Department, and the information is shared with the program's management team meetings daily. A review of the provider's contractual agreement found amendment eight, which focused on implementation of retention bonuses for direct care staff workers. In addition to bonuses, the program has an employee morale committee who hosts staff dinners and activities. The program has a system of recognizing staff positive performance, which consists of administrative staff giving tokens to any program staff they find working above and beyond in their job duties. Those who receive any earned tokens are to immediately turn in the token to the human resources department, then will be eligible for winning various raffles and prizes. The program conducts various staff meetings on a regular basis. Supervisor meetings are done twice monthly, staff management meetings are completed monthly, management meetings are done daily, and shift briefings are done prior to each shift. Documentation of meeting minutes, sign-in sheets, and agenda topics were reviewed for all meetings to confirm the practice. Five staff were interviewed regarding staff communication and program planning. Five staff reported meetings are held monthly, and one staff reported they were held daily. All staff were able to summarize topics discussed during meetings, such as attendance, expectations, programmatic issues, alerts, and improvements needed. When asked if staff were briefed on any annual reports, four responded yes, and one staff stated no. Four staff reported they felt the communication at the program was good, and one staff reported it was fair. All staff summarized they felt they could provide feedback to administration within the program if needed. The facility administrator was interviewed concerning program planning, staff retention and turnover, and stated overall competition in the area is a challenge. There are different providers which have competitive salaries targeting staff. Another challenge is staff turnover. The facility administrator reported he has noticed a decline with increased morale functions like cookouts, potlucks, movies, and bowling. Also, staff acknowledgments like awards has also helped with retention. The facility administrator reported the outcome date used by the program includes things such as exit parent/guardian surveys, family sessions, individual sessions, and treatment team. The Florida director shares CAR information with the facility administrators and the information is then passed on to the management team.

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 addressing staff performance and the administering of formal evaluations. The procedure indicates all staff receive an evaluation after the initial ninety-days from their hire date, and then annually thereafter. A sample of three performance evaluations were reviewed for the positions of therapist, youth care worker, and transition case manager. All three personnel records included evidence the evaluations were

completed as required. Job descriptions for these positions were also reviewed and ensured each staff member's performance standards were clearly identified. The performance standards matched job descriptions for each staff. A review of key positions outlined with the provider's contract revealed all key positions were currently being maintained in the program. An interview with the facility administrator revealed all staff are provided evaluations. Five staff were interviewed. All indicated they have received evaluations while employed at the program.

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

The program has a policy and procedures which addresses recreation and leisure activities. The program employees a recreational therapist who develops wellness plans for youth and constructs activities, while providing youth a choice of leisure and recreation options. A review of the recreational therapist's personnel records revealed they have received the appropriate training and educational experience required for the position. The recreational therapist was interviewed, and stated youth are encouraged to explore interest and are engaged in constructive use of their leisure times. A review of the logbook found activities were documented according to the program's activity schedule. The schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities. The activities promote social and cognitive skill development, teamwork, and physical fitness. During the week of the annual compliance review, observations were made of youth engaging in recreation activities. The recreational therapist participates in all youth formal treatment team meetings to discuss each youths' formal wellness plan developed. Five interviewed staff were all able to summarize various indoor and outdoor activities provided for youth. Five interviewed youth all responded they were provided with varying degrees of mental and physical exertion throughout the day.

Standard 2: Assessment and Performance Plan

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

Five case management records were reviewed to verify initial contact with a parent/guardian by phone within twenty-four hours and by writing within forty-eight hours, of admission. In all five records, telephone contact with the youth's parent/guardian on the day of admission was made and documented in the chronological notes of the youth's case management record. In all cases, staff mailed a letter to parents/guardians, the court, and the juvenile probation officer (JPO) within forty-eight hours, notifying the youth was admitted to the program.

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

Each of the five case management records found orientation took place within twenty-four hours of each youth's admission to the program. The orientation process covered services available, daily schedule, youth expectations and responsibilities, written behavior management system, availability and access to medical and mental health services, access to the Florida Abuse Hotline and/or Central Communications Center (CCC), program's zero-tolerance policy regarding sexual misconduct, special accommodations available to youth, items considered contraband, performance planning process, dress code and hygiene practices, procedures on visitation, mail, and use of the telephone, expectations for release from the program, community access, grievance procedures, emergency procedures, facility tour, assignment to living unit and room, and medical topics. In all five records, the youth initialed all boxes to indicate understanding of program rules and expectations. The program did not have a youth admission during the annual compliance review, so an admission and orientation could not be observed. All five youth interviewed confirmed orientation to the program began within twenty-four hours of arrival and the program's rules, procedures, and schedules were all explained.

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.	

One of the five youth records selected for review, was with a youth who turned eighteen years of age at the time of admission to the program. One of the three youth closed case management records reviewed, contained a youth who turned eighteen while in the program. Both records included a written consent form for youth eighteen years of age. Both forms were signed by the youth and obtained before releasing any information relevant to the youth's treatment, assessments, and screenings to parents/guardians.

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

Five case management records were reviewed for classification factors, procedures, and reassessments for activities. The initial classification was administered on the day of admission in all five records reviewed. The classification assessment included physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, and criminal behavior. Risk factors were assessed and identified by suicide risk, medial risk, escape risk, and security risk in all five records reviewed. Sexually aggression or vulnerability to victimization was assessed through the Victimization and Sexually Aggressive Behavior (VSAB) screening instrument, were completed on the day of admission in all five records. All five youth records reviewed were applicable for reassessments and their classifications were updated accordingly every month. The program's policy and procedures outlined the classification process and review of the program's internal alert system included the classification results and was also updated accordingly.

During the facility administrator's interview, he explained, treatment team conducts a classification meeting. This included, the director, assistant facility administrator, clinical director, assistant clinical director, case manager, nurse, and/or parent/guardian via telephone. This classification is designed to gather the youth status information, as well as any gang involvement. The information is shared with the administration and is used to determine room assigned to the youth. The room assigned can be based on VSAB results.

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.	

Two additional youth records, which were the only two applicable records for gang identification, were provided for review. Staff completed a gang assessment as part of the orientation into the program at the time of admission in both applicable records. Both records included notification to law enforcement regarding gang identification for youth admitted to the program. Notification to law enforcement included a letter sent to local law enforcement, law enforcement in the youth's home county, the local school district, and the youth's juvenile probation officer. The gang liaison presented a binder which contained documentation showing notification was made to the appropriate law enforcement agencies for each youth identified.

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.	

Five case management records were reviewed to assess if the program is providing intervention strategies to youth identified as gang affiliated, members of a criminal street gang, or youth who are identified as a high risk for involvement in gang activity. The two applicable records reviewed included gang interventions in the youth's performance plans. Monthly Impact of Crime (IOC) groups on gang interventions are also conducted and monthly sign-in sheets documenting the attendance of each youth were kept in the gang binder of the program's gang liaison. The program's policy and procedures ensure all identified youth participate in IOC, which was verified on the youth's performance plans.

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 case management records were reviewed and were compliant in completing the initial Residential Assessments for Youth (RAY) within thirty days of admission to the program and maintained in the Department's Juvenile Justice Information System (JJIS). All five records also reflected the RAY Reassessments were completed within the ninety-day time limit, or as-needed if a change in interventions were needed prior to the ninety days. All five records contained documentation of the initial assessment and subsequent assessments.

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

Five youth records were reviewed to determine if a Youth Needs Assessment Summary (YNAS) was completed and documented within thirty days of admission to the program. All five records showed staff conducted the YNAS within the allotted timeframe and documented the assessment in the Department's Juvenile Justice Information System (JJIS), as required.

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

Five youth records were reviewed for the development of performance plans completed within thirty days of admission to the program in all five records. All five performance plans were developed and signed by all members of the treatment team. The treatment team consists of the treatment leader, youth, an administrative representative, living unit representative, treatment staff, and education staff. All five performance plans were developed after the initial Residential Assessment for Youth (RAY), as required. Each of the five plans contained goals which were individualized based on the risk factors and protective factors outlined in the RAY. All five plans also addressed the youth's top three criminogenic needs. Each of the five performance plans contained action steps for the youth and program staff to complete, target court-ordered sanctions, and transition activities targeted for the last ninety-days; for the youth to reach their goals and target dates. A copy of the completed plans were provided within ten working days to the parents/guardians, youth, and juvenile probation officers; and the committing court were sent a copy of the plan in all five records reviewed.

All five youth were interviewed and able to explain the program's treatment process which indicated their knowledge of the treatment process. Four of the five youth interviewed reported they received a copy of their performance plans and one youth stated he did not receive a copy.

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

Four of the five case management records were applicable for revisions to the performance plan. All four applicable youth records had the Residential Assessment for Youth (RAY) changes included. All four records included progress towards completing the youth's goals. All four records included transition activities. One of the records included a Performance Plan Revision, completed a month before the revision was required. It did not have any newly acquired information or progress in completing the youth's goals.

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.*	

Four of five youth records were applicable for review of the performance summaries which contained the status of each youth's goals, treatment progress, academic status, behavior, level of motivation, interaction with staff and peers, adjustments to the program, significant positive and negative events, and justifications for release. All ninety-day summaries were completed within ninety days and signed by all members of the treatment team. Documentation showed in all four records reviewed, youth were allowed to read and add comments prior to signing, provided a copy of the summary, and the original summary was filed in the case management record. All four records showed the juvenile probation officer (JPO), parents/guardians, and committing court; were provided a copy of the performance summaries within ten working days of completing the document. One of the open youth records reviewed was applicable for review of Release Summaries, along with three closed youth records. All four records contained documentation showing of the release summary and copy of the Pre-Release Notification completed ninety-days prior to planned release from the program and sent to the youth's parents/guardians and JPOs. The court approved the youth's release and an exit Residential Assessment of Youth (RAY) was completed within the required timeframe for all three closed records reviewed. The open youth record with the release summary did not have the approved PRN returned. The program also provided all three of the youth's JPOs with a copy of their performance summary, physical health summary, and transition plan. Victim notification letters were not provided for four youth to review. Three youth reported they received a copy of the performance summary, one youth said he did not, and one youth was not applicable because he had not been at the program long enough to require a ninety-day performance summary.

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

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

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

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

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

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

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

Five case management records were reviewed for documentation of the treatment team process. All five of the records contained documentation showing treatment teams occurred in a formal capacity every thirty-days with the required meeting attendees confirmed by the signatures on the treatment team sign-in sheets. Each treatment team documented the youth's treatment progress, Residential Assessment of Youth (RAY) results, and progress toward performance plan goals. There was documentation indicating all appropriate parties were invited to participate in the meetings, to include the juvenile probation officer (JPO), parent/guardian, and relevant stakeholders. Informal treatment team reviews took place every two weeks, as required, for all five youth. Documentation included the youth's treatment progress and discussed skills the youth acquired in the program. Five youth answered affirmative when asked if staff reviews youth performance to include progress on performance plan goals, positive and negative behavior, and treatment progress. All five youth interviewed reported they were given an opportunity during treatment team meetings to demonstrate any skills learned.

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

The program provides Type 2 educational programming which is based on each youth's age, length of stay in the program, and their assessed educational abilities and goals. Career education programming includes training in communication, interpersonal, and decision-making

skills. Three closed youth records were reviewed for career education completion. All three records contained résumés summarizing youth's skills and experience, documentation of appointments with the youth's local Career Source Center, appropriate documents essential to obtaining employment, and completed job applications. Each of the records also included documentation indicating the youth's parent/guardian and juvenile probation officer were made aware of the youth's vocational plan. The school principle was interviewed and reported youth use Career Shines and Florida Shines along with various activities within the classrooms. Each youth has a login and it is also within the class lesson plans.

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.	

Various documentation was reviewed to determine compliance for educational access including logbooks, observation during the day, school schedule, video footage to validate times/dates, and interviews with the principle and facility administrator. The school is required to provide 300 minutes a day of educational instruction to youth for five days a week, Monday through Friday. The logbook review indicated the youth were approximately late to class several times in two months. However, the program staff reviewed video and it was determined the class count was called in after the youth were in the classroom and settled in their perspective seats.

Four youth, when asked, reported there were no interruptions to the class schedule and one youth reported yes, there were interruptions. The school principle reported the school determines whether a youth will be placed on a Generalized Equivalency Diploma (GED) "track" which includes pretesting and additional remediation. If a youth is Exceptional Student Education (ESE), we use various accommodations according to their Individualized Education Plan (IEP), the school assigns credit recovery courses to the youth as needed.

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

Three closed case management records were reviewed to determine if the transition plans contained appropriate youth goals, once released from the program. Each of the three closed youth records reviewed had an education plan which was developed. Education transition plans were missing signatures of the youth, parent/guardian, and education staff which could not verify their involvement. Interview with the case management staff reported the education transition plans are reviewed and signed by youth, family, and education staff. The principle was interviewed and did not have signed copies of the education transition plans. The plan also included educational placement upon returning to the community. All three records reviewed included services and interventions post-release, recommended educational placement based on individual needs, provisions for continuation of education and/or employment, sample employment applications, résumés, valid Florida identification, location and hours of local Career Source Centers, and appropriate documentation essential to obtaining employment. None of the three records outlined specific responsibilities for the parties involved in coordinating support services for the youth in the community.

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.*	

Two of the open case management records and three closed case management records were reviewed for youth who participated in a transition conference. One of the open records and three closed records were reviewed for the Community Re-Entry Team (CRT) meeting. In all five records, transition conferences were held, at least sixty-days prior to the targeted release date in all five youth records. The youth, treatment team leader, facility administrator or designee, and other team members were notified and participated in the transition conference in all five records, verified notification letters and by the signatures on the sign-in sheet. During the transition conference, transition activities were reviewed, revised performance plans were provided, target completion dates, and persons responsible were identified. A copy of the transition performance plan was sent out to all attendees. All four records showed the CRT meeting was conducted prior to the youth's release, as well as the youth and case manager were invited and participated in the CRT meeting.

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

Three closed case management records were reviewed to ensure the program properly assembled an exit portfolio for each youth to take into the community upon release. Each of the three closed youth records reflect the exit portfolio was discussed at the transition conference, as required. All three of the exit portfolios contained either a State of Florida identification card, birth certificate, and/or social security card or the closed youth record contained letters of intent to obtain the items on behalf of the youth. A copy of the youth's transition plan, education records, a calendar of appointments in the community, a résumé, transcripts, and a sample job application were included in all three youth records. All three youth were provided a copy of the exit portfolio to take with them and a copy was forwarded to the juvenile probation officer (JPO).

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

Three case management records were reviewed to determine if all of the required elements for the exit conference were present. All records contained documentation indicating the juvenile probation officer (JPO) was invited to participate in the exit conference. All three exit conferences took place within fourteen days of the youth being released from the program. There was documentation indicating the transition activities were reviewed and finalized by the attendees which included the youth, treatment leader, education representative, JPO, and parent/guardian.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed psychiatrist who serves as the designated mental health clinical authority. The psychiatrist's license is clear and active and is licensed under the state of Florida. The license expiration is January 31, 2010. The licensed mental health counselor (LMHC), who serves also as the clinical director, has a clear and active Florida license, expiring March 31, 2021. The clinical coordinator is a full-time employee and is responsible for providing oversight for six therapists and four case managers for both the non-secure and secure components of the program. A copy of the licensure and position description was available for review while on-site. In addition, the program has a contract with a licensed psychiatrist who is board certified in psychiatry. The psychiatrist is on-site for a total of four hours weekly, Monday through Friday. The psychiatrist's license has an expiration date of January 31, 2020. The program provides specialized treatment services; mental health overlay services (MHOS) for twenty-four beds. All clinical staff licensures and position descriptions were available on-site for review.

The LMHC was interviewed and reported she is on-site forty hours a week, Monday through Friday from 9:00 a.m. until 6:00 p.m., and as needed. She indicated her role was to oversee the implementation of mental health and substance abuse services provided by master's-level therapists and case management staff. In addition, she completes fidelity monitoring of therapeutic services, daily checking of the billing and documentation, and auditing charts as well as tracking due dates for assessments. Group and individual therapy sessions are provided for youth. The program utilizes developmentally-appropriate evidence-based curriculums. The level of communication within the staff occurs daily, both verbally and through email. There is also a group supervision weekly for one hour which all clinical staff are required to attend. In addition, meetings with the psychiatrist occur every two weeks.

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

The program has a licensed mental health professional, who serves as the designated mental health clinician authority (DMHCA), licensed under chapter 491, Florida Statutes. The program has an independent contract agreement with a psychiatrist, who has completed a psychiatry program approved by the American Board of Psychiatry and Neurology, licensed under Chapter

459, Florida Statute and meets all requirements outlined within Florida Administrative Code 63N-1. The psychiatrist's license is clear and active and expires January 31, 2020. The psychiatrist has specialties in pediatrics, child and adolescent psychiatry. Licensures for all qualified mental health professionals were available on-site for review.

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 clinical coordinator who serves as the designated mental health clinical authority (DMHCA), ensures therapists and case managers are performing services, and are qualified based on their education, training, and experience. All hold the appropriate level of education necessary and are in accordance with the contract between the provider and the Department and Florida Administrative Rule 63N-1. Each of the non-licensed clinical staff hold a master's-level degree from an accredited university. The program currently has one therapist vacancy. The clinical coordinator conducts weekly on-site, face-to-face interaction with each of the non-licensed clinical staff; which are at least one hour for each contact. All face-to-face supervisions occurred as required. Each of the face-to-face supervisions conducted were recorded on a similar form to Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019), which included all necessary information. The program is licensed under Chapter 397, to provide substance abuse treatment services; certified by the Department of Children and Families (DCF). Each of the non-licensed clinical staff have received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The non-licensed clinical staff's training was documented on the non-licensed mental health clinical staff person's training in Assessment of Suicide Risk (ASR) form.

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

Each youth is administered the Massachusetts Youth Screening Instrument -Version II (MAYSI-2) and staff have the needed training to administer the screening and make referrals as needed. Five of five youth records contained the required MAYSI-2 screenings and related referrals. Each of the MAYSI-2 screenings were conducted by trained staff on the day of each youth's admission. The program also uses the Assessment of Suicide Risk (ASR) to screen youth at intake and remove them from precautions if deemed appropriate. None of the five youth required an ASR. Four of five required a comprehensive evaluation. In all four of these applicable records, they included a documented reason for referral. The MAYSI-2 screenings were administered in the Department's Juvenile Justice Information System (JJIS). All five screenings were conducted by case management staff who had completed the appropriate MAYSI-2 training within the Department Learning Management System (SkillPro). Clinical screenings for all five youth addressed each of their mental health and substance abuse history, history or trauma of victimization, current medical status, behavioral observations, and findings and recommendations.

The program has a written policy and procedures, which is developed by the program director. The policy addresses the implementation of a standardized admission and intake mental health and substance abuse screening process. The policy included following elements: a standardized screening process which included the review of commitment packet information, reports, and records. The administration of the MAYSI-2 on the Department's Juvenile Justice Information System (JJIS). Each screening administered is conducted by a qualified and trained staff, and a referral made for youth identified in need of further evaluation or immediate attention when necessary. The policy also identified staff training in mental health and substance abuse issues and administration of the MAYSI-2. In addition, the policy identified standardized process for referral of youth identified as in need of further mental health and/or substance abuse evaluation to an appropriate service provider or professional or, when immediate attention is needed, to a hospital or Baker Act or Marchman Act receiving facility. A review of five separate youth records, demonstrated the program staff conducting screening, reviewed youth's commitment packet information, reports, and records for existing documentation of mental health and/or substance abuse problems, needs, or risk factors. An interview with the program director was conducted. The program director was asked, what is the screening process to identify youth at risk for mental health and substance abuse problems and suicide, and indicated the program utilizes the MAYSI-2 and ASR.

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

Five youth records were reviewed for a mental health and substance abuse assessment/evaluation. Each of the youth records reviewed had a new mental health evaluation completed within thirty calendar days of admission. All of the new mental health evaluations were conducted by a non-licensed mental health clinical staff, then reviewed and signed within ten days by a licensed mental health professional. All the new mental health evaluations conducted, contained demographics, reason for evaluation, relevant background information, behavioral observations, mental status examination, discussion of findings, diagnostic impression, and recommendations for each youth.

Five youth records reviewed for completion of a substance abuse assessment. Each youth record had a new substance abuse assessment completed. Each of the five-youth records reviewed, contained a signed consent for substance abuse services, from the youth. The substance abuse assessments were completed within thirty calendar days of admission. The new substance abuse assessments contained a reason for assessment, relevant background information, behavioral observation, methods of assessment, patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, risk factors of continued alcohol and other drug abuse, clinical impression to include diagnoses from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-IV-TR), and recommendations. Each of the five new substance abuse assessments conducted, addressed the youth's original referral reason.

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.*	

Five youth records were reviewed for mental health and substance abuse treatment. Each of the youth records reviewed, indicated the youth were assigned to a treatment team upon arrival to the program. The multidisciplinary treatment team were comprised of the youth, program administration, direct care staff representative, and other staff responsible for delinquency intervention and treatment services for the youth. For each of the five records reviewed, treatment team documentation validates it is comprised of representatives from administration, education, vocational training, medical staff, mental health staff, substance abuse staff, youth, and when possible the youth's parent/guardian. All five of the youth reviewed were determined to be in need of substance abuse treatment. The youth were in receipt of one or more of the following; individual, group, family counseling, and or psychiatric medication management. The substance abuse treatment at the program is provided by a licensed qualified professional or a non-licensed substance abuse clinical staff, who works directly under the direct supervision of a qualified professional. In addition, each of the five youth records reviewed, were applicable for mental health treatment. The five-youth reviewed, each had a properly executed Authority to Evaluation and Treatment (AET) form contained within in their respective individual health care record. Each youth in receipt of services had documentation of a clinical impression to include diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5). All five youth records reviewed for substance abuse treatment contained a signed substance abuse consent and release form; forms were completed on the Department Youth Consent for Substance Abuse Treatment and Youth Consent for Release of Substance Abuse Treatment Records forms. Mental health and or substance abuse treatment notes were completed on the provider's form, which contained all the required information within the Department's Counseling/Therapy Progress Notes form. A review of youth sign-in sheets for mental health treatment groups, documented the groups did not exceed eight participants. Documentation indicated youth had also been working in individual counseling with a mental health clinical staff professional. Each of the five youth records contained documentation the youth were involved in individual psychotherapy or counseling. Youth were engaged in therapeutic activities designed specifically to address skill deficits or maladaptive behaviors. An interview was conducted with the program's designated mental health clinician authority (DMHCA). The DMHCA was asked, does the program offer any type of specialized services and, if so, how do you ensure these services are delivered in a manner consistent with contractual requirements. The DMHCA replied, stating the services for the youth who are borderline and developmentally delayed are provided in group and individual therapy sessions. The program uses developmentally-appropriate evidenced-based curriculums which are monitored for fidelity by licensed level staff.

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.*	

Five youth records were reviewed for youth treatment planning. All five contained an initial mental health and substance abuse treatment plan. The initial mental health and substance abuse treatment plans were site-specific, which included all the information contained within the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Each of the five youth records reviewed, had an initial mental health and substance abuse treatment plan developed within seven days of admission to the program. All initial treatment plans were completed by a non-licensed mental health clinical staff person and later reviewed and signed by the licensed clinical supervisor within ten days of completion. Each of the initial treatment plans were signed by treatment team members who participated in the development of the plan, with the exception of the parent/guardian for four of the five plans reviewed. Only two of the five youth were receiving prescribed medication at the time reviewed. For these two records, the initial treatment plan included the youth's psychiatric needs, including medication frequency of monitoring by the psychiatrist. Five youth records were reviewed for development of an individualized treatment plan and reviews. All the youth records reviewed, contained an individualized treatment plan, which was developed within thirty days of the youth's admission to the program. The five individualized treatment plans reviewed, were developed on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. Each of the applicable individualized treatment plans were completed by a non-licensed mental health clinical staff person and were subsequently reviewed and signed by the program's licensed clinical supervisor within ten days of completion. The plans were all signed by all treatment team members, who participated in the development of the plan, with the exception of the parent/guardian in three records. These three documented messages were left for the parent/guardian by telephone. Prescribed services were documented in each of the applicable individualized treatment plans. A review of progress notes was completed to determine each youth received services as stipulated on the treatment plan. Three additional closed youth records were reviewed for discharge planning. Each of the three discharge plans were documented on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form. None of the three-youth reviewed were applicable for any type of notification for suicide risk or precautions. Each of the mental health and substance treatment discharge summaries documented the services required for daily maintenance of positive improvement in behavioral, emotional, and social skills made by youth during treatment. All three discharge plans contained documentation of the discharge plans having been discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. Copies of the mental health and substance abuse treatment discharge summaries were provided to the JPOs, parents/guardians, and youth in each record reviewed.

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

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

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****	

Five youth records were reviewed for psychiatric service delivery. All of the youth records reviewed, were referred to the psychiatrist. Two of the five youth were on psychotropic medications upon admission to the program. Each of the youth referred were seen within fourteen days of the referral. Each of the initial diagnostic psychiatric interviews included a youth history, mental status examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5), treatment recommendations (if applicable), prescribed medications (if applicable), explanation of the need for psychotropic medication, and frequency of medication monitoring. For the two youth who were receiving medications upon admission, the initial diagnostic interviews with the psychiatrist were documented on the Clinical Psychotropic Progress Note (CPPN). The initial diagnostic interviews were labeled as an "initial diagnostic psychiatric interview". Page three of the CPPN was used to document the psychiatric interview. This was observed completed for the two applicable youth records reviewed, indicating these youth arrived at the program with prescribed psychotropic medications. Each youth received a psychiatric evaluation within thirty days of the intake. The evaluations reflected all elements specific within Florida Administrative Rule 63N-1. The program has an independent contract agreement with a psychiatrist, who has completed a psychiatry program approved by the American Board of Psychiatry and Neurology, licensed under Chapter 459, Florida Statute

and meets all requirements outlined within Florida Administrative Code 63N-1. The psychiatrist's license is clear and active and expires January 31, 2020. The psychiatrist has specialties in pediatrics, child and adolescent psychiatry. A copy of the contract between Youth Opportunity Investments (YOI) and the psychiatrist was available for review while on-site. The program does not have a psychiatric advanced registered nurse practitioner (ARNP). The psychiatrist is on-site every two-weeks and is available to evaluate and monitor youth, as needed. Each youth prescribed psychotropic medication, receives psychotropic medication monitoring and review at a minimum of every thirty days. The psychiatrist is available for on call and emergency consultation twenty-four hours a day, seven days a week. A review of the program's psychiatric sign-in sheets for the psychiatrist, confirms his visits during the past six months, validating he was on-site every two-weeks. The psychiatrist is ultimately responsible for the prescription and monitoring of psychotropic medications at the program. A review of youth records revealed the psychiatrist actively participates in, manages, and supervises psychotropic medication service within the program. There were no indications of the program having any standing orders for psychotropic medications. In addition, there were no indications of any emergency treatment orders for psychotropic medications. The psychiatrist was interviewed and stated he is responsible for approving psychiatric policies and procedures, conducting initial psychiatric evaluations, and monthly medication management. He stated he is on-call twenty-four hours each day, seven days a week. He indicated he has no concerns with the health care provided by the program.

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

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

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

The suicide response kits were observed and contained a knife-for-life, wire cutters, and needle nose pliers, as required. The program does enter alerts into the Department's Juvenile Justice Information System (JJIS). All applicable alerts were entered and discontinued, as required, in the Department's JJIS. Five staff interviews reflect all staff know the suicide response kits are in master control and are participating in drills which may require crisis intervention/suicide prevention. No issues were noted with the suicide prevention services. No secure observations were available for review. Five of five interviewed staff members identified the knife-for-life is in the master control room. During the annual compliance review, these items were observed in master control and contained the knife-for-life, wire cutters, and needle nose pliers as is required. The facility administrator has a suicide prevention plan which includes all required elements.

A total of five youth records were reviewed for suicide prevention services. All youth reviewed had an Assessment of Suicide Risk (ASR) completed upon admission to the program. Each of the youth reviewed were placed on precautionary observation at admission, while the youth were assessed for suicide risk. An ASR referral was generated for each of the youth reviewed. Each youth had an ASR completed using the required Department's ASR form. Four of five youth were screened and subsequently placed on standard supervision. The remaining one youth was placed on constant supervision. Precautionary observation (PO) logs reviewed documented youth being supervised at a minimum every thirty minutes, for the duration of time the youth was on PO status. The PO status was authorized, and mental health staff provided supportive services, as needed. Only one of the five-youth reviewed, required any type of follow-up ASR. A follow-up ASR was completed for this youth. All required elements of the Follow-up ASR were completed by the program's licensed mental health professional. A conference was subsequently held by the licensed mental health professional and facility administrator to reduce the level of supervision for this youth. The discontinuation of close supervision was documented in accordance with the program's suicide prevention plan. The parent/guardian was notified of the ASR findings. A JJIS alert was initiated for the one youth placed on precautions and was removed once returned to standard supervision. In addition, there was evidence in the facility logbook supervisors were provided instructions related to suicide risk assessment findings and suicide precaution decisions for this youth.

Those youths placed on PO are able to participate in select activities with other youth in designated safe housing observation areas of the facility. Placement on PO does not limit a youth's activity to an individual cell or restrict him to his sleeping quarters. None of the youth assessed were determined to be in crisis upon admission to the program. None of the ASRs were conducted outside of the program. A review of the program's logbook and shift debriefing revealed instructions pertaining to those youth placed on suicide precautions when necessary.

There is no indication the program has had any youth placed on secure observation during the annual compliance review period. Discussion with the DMHCA, also supports the program has not had any youth placed into secure observation.

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

The program had one youth record for the scope of the annual compliance review, which was applicable for containing suicide precaution observation log. The logs were maintained for the duration the youth was on precautions. Documentation was completed in real time not exceeding thirty-minutes. The logs are reviewed and signed by each supervisor and the mental health staff. The logs document safe housing requirements. The one youth was interviewed and agreed while on suicide precautions, staff remained with him at all times.

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

Five pre-service and five in-service staff trainings records found each had received the required suicide prevention training. Suicide prevention training is to train staff to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions. Suicide prevention training was provided to each staff as required. Mock drills were conducted quarterly on each shift and contained the needed requirements. Direct care staff participate in quarterly drills, which include training for cardiopulmonary resuscitation (CPR).

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 services plan which addresses those practices necessary to effectively handle youth in need of a mental status exam and crisis assessment. The plan includes a notification and alert system, means of referral including self-referral, communication, supervision requirements, documentation, and a system of review.

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

The program had one youth record applicable for requiring a crisis assessment. For this record, there was evidence the assessment was completed. It included the reason for assessment, mental status examination, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, treatment recommendations and follow-up, and notification to parent/guardian. The assessment was conducted by a licensed mental health professional within the timeframe required based on the need of the youth. A mental health alert was placed into the Department's Juvenile Justice Information System (JJIS). The alert remained until the follow-up mental status examination was completed. One on one constant supervision was documented on the Department's Suicide Precautions Observation Log form. The log utilized indicated the appropriate supervision was maintained.

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

The program had a written emergency mental health and substance abuse services plan. The written emergency mental health and substance abuse services plan includes, the following: immediate staff response, notification, communication, supervision, authorization to transport for emergency mental health services or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act), documentation, training, and a review process.

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

The program had one youth applicable for completion of a Baker Act referral. The referral was generated due to the youth displaying suicidal behaviors. The youth was placed on one-on-one supervision at the time of discovery. Mental health staff were notified, and the youth was taken out of the facility for the Baker Act referral made, and for further evaluation. Upon return, the

youth was placed on constant supervision, and a mental health referral was completed indicating a Mental Status Examination (MSE) was conducted. The Assessment of Suicide Risk (ASR) was completed under the supervision of a licensed mental health professional. The youth was maintained on constant supervision until transitioning to a lower level of supervision, but not until an ASR was conducted, and mental health staff conferred with the licensed mental health professional and the facility administrator.

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 designated health authority (DHA). The DHA is a licensed physician (medical doctor) who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. The DHA has a clear and active license, with an expiration date of January 31, 2020. The physician's specialty training is in family practice. The program does not employee a physician assistant (PA) or advanced registered nurse practitioner (ARNP). A review of weekly sign-in sheets for the past six months, demonstrates the DHA is on-site at least once a week. The DHA is scheduled to be on-site each week, on Mondays. A review of sign-in sheets revealed, at no time was there more than nine days between on-site visits for the DHA. The DHA has not been out on vacation or scheduled absence within the past six months, which would have required any medical doctor coverage at the program. Pursuant to the contract between the program and DHA, he is responsible for communication with program staff regarding each youth's medical needs and is available for consultation by phone or electronic means, twenty-four hours a day, seven days a week. The program has written facility operating procedures, which are specifically developed for medical services. Each of the four medical professionals providing care to youth, have clear and active licenses.

The DHA was interviewed and stated his role at the program, consist of being on-site weekly and on call twenty-four hours a day, seven days a week. He will see all youth for completion of Comprehensive Physical Assessments (CPA), periodic evaluations, sick call follow up (when needed), review of any off-site visits, and facility operating procedure development. The DHA participates in quarterly interdisciplinary risk reduction/quality improvement and infection control meetings. The DHA also confirmed he performs all on-site clinical services to youth and does not have a designee, ARNP or PA. The DHA ensures all off-site care findings, instructions, and information is reviewed weekly; this is accomplished when the health services administrator (HSA) provides him with a binder for review. The DHA meets weekly with the program HSA to review the important medical issues pertaining to the youth at the program. The DHA conducts at a minimum every ninety days periodic evaluations for youth with chronic conditions.

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

The program has written facility operating procedures (FOP) for all health-related procedures and protocols utilized at the program. The program's designated health authority (DHA) and facility administrator sign and date all respective treatment protocols and FOPs. All nursing staff review, sign, and date a cover page on which all FOPs, treatment protocols, and other procedures are listed. An annual review of all FOPs and protocols was lasted conducted on November 11, 2019. The medical department has had two new nursing staff hired since the last annual compliance review. Each of the newly employed health care personnel received a comprehensive clinical orientation to the Department's health care policies and procedures; which was conducted by the on-site health services administrator (HSA). Each of the treatment protocols and or standing procedures were written and authorized by the programs DHA. The

review and development of FOPs, and or other protocols related to psychiatric services and psychotropic medication management were only conducted 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 total of five Individual Healthcare Records (IHCR) were reviewed for completion of the Authority for Evaluation and Treatment (AET) documentation. Four youth records contained either an original AET or a legible copy, with the word copy stamped on the AET. The remaining one youth out of the five, was nineteen years old; his AET is no longer in effect once the youth turns eighteen years of age. Copies of completed parental notifications are maintained behind the AET in each of the applicable youth's IHCR. None of the records reviewed had evidence the youth were in the care of the Department of Children and Families (DCF) where there has been a termination of parental rights. The on-site nursing staff was interviewed and provided; the program's policy for obtaining a new or current AET is conducted when a youth arrives to the facility, there is a completed AET with the parent/guardian signature. The AET shall remain in the youth's healthcare record with 'COPY' stamped on each page. In addition, for those youth who are eighteen years or older, a separate consent for treatment is required. The youth will be able to provide their own consents once they turn eighteen years old.

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 total of five Individual Healthcare Records (IHCR) were reviewed for parental notification and consent requirements. All applicable records contained documentation of parental notifications for over-the-counter (OTC) medications beyond those covered by the Authority for Evaluation and Treatment (AET). Each of the five IHCRs were applicable and contained documentation for vaccinations and immunizations not consented for on the AET. Three of three applicable records had notifications of significant changes to existing medication regimen (not including psychotropic medication). None of the youth required any discontinuation of medication prescribed prior to the youth entering the custody of the Department. Four of four applicable records had notifications for changes in condition/medication for youth with chronic conditions. None of the youth required any parental notifications for off-site emergency care, hospitalizations, surgeries/invasive procedures, and or non-routine type dental procedures. Two of two applicable records had evidence the parent/guardian was notified when youth were taken off-site for routine medical treatment. For new medications, verbal attempts were documented in the progress notes for two of two applicable records. Written notifications are sent regardless of telephone notifications. A staff member signed indicating as a witness for all call attempts and conversations. None of the records reviewed had evidence the youth were in the care of the Department of Children and Families (DCF). Two of two applicable records had documentation of notification when a psychotropic medication was initially prescribed, discontinued, or drug dose changed. The parent/guardian verbal consent was documented through page three of the Clinical Psychotropic Progress Note (CPPN). Written consent was also documented on the Acknowledgement of Receipt of the CPPN and contained parent/guardian signatures. Each of the IHCRs reviewed, contained documentation vaccinations were verified within thirty days of each youths' admission. There were no youth applicable were consent was needed prior to administering a vaccination within thirty days of the youth admission. None of the IHCRs

reviewed, required any type of religious exemption from immunization. None of the IHCRs reviewed were applicable nor required a signed letter by the youth's physician indicating a reason for an exemption. The on-site nursing staff indicated, if a parent/guardian exempts from a youth receiving an immunization the parent/guardian must send a written consent by mail. A letter must be sent to the facility from the Department of Health (DOH) or the physician. If the exemption is due to religious preferences, there must be a religious exemption from immunization form completed. The health services administrator (HSA) also outlined the program practice for informing a parent/guardian when obtaining consent for psychotropic medications. When a new psychotropic medication is ordered verbal consent must be given by the parent/guardian before starting the new medication along with a written consent with page 3 of the CPPN attached. If a psychotropic medication has a dosage change or is discontinued the parent/guardian is notified verbally along with the written notification with the CPPN attached. Verbal consent is witnessed and documented. The HSA also outlined the process for ensuring timely parental notifications, whereas, parents/guardians should be notified of any changes in the youth's healthcare status and medication changes. Notification should be made by telephone, charted in the progress notes, and followed up by a written notification.

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 total of five Individual Healthcare Records (IHCR) were reviewed for completion of a Facility Entry Physical Health Screening (FEPHS) form upon admission. Each IHCR reviewed, contained a completed FEPHS on the date of the youths' admission to the program. All FEPHS forms, were completed by a registered nurse (RN). Two of two applicable youth required the completion of a new FEPHS due to a change in physical custody since the youth's arrival. In both cases, the program completed a new FEPHS re-screening of the youth for each returning date after the change in custody occurred. Each of these FEPHS forms, were completed by the program's RN. The on-site nursing staff was interviewed. Healthcare staff completes the FEPHS upon entry to the facility. Non-healthcare staff can complete the FEPHS if healthcare staff is off-site. Should a direct care staff complete a FEHPS, it must then be reviewed by healthcare staff within twenty-four hours.

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 total of five Individual Healthcare Records (IHCR) were reviewed for youth orientation to health services and health education. Each of the IHCR contained documentation were each youth was in receipt of general healthcare orientation upon admission to the program. A review of the program's written facility operating procedures, provided insight into the practices to be performed by the medical staff for each youth upon admission for orientation to health services. Topics covered within the program's healthcare orientation included, access to medical care, sick call, what constitutes an emergency, medication process (side effect monitoring), the right to refuse care, what to do in the event of a sexual assault, and the non-disciplinary role of health care providers. All healthcare education/orientation provided to each youth, is documented on the Health Education form and was filed in the health education section of the IHCR.

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 total of five Individual Healthcare Records (IHCR) were reviewed for notification to the program's designated health authority (DHA)/designee upon a youth's admission for those youth with known or suspected chronic conditions. Each of the youth reviewed had appropriate referral to the DHA/designee upon the youth's admission to the program. None of the youth reviewed, were in need of an emergency response at the time of admission. All five IHCRs reviewed, contained evidence of a telephone notification to the DHA upon the youth's admission. Each of these notifications, were found in the chronological progress notes within each IHCR reviewed. The on-site nursing staff was interviewed. Nursing staff stated the DHA is to be notified of the youths' chronic condition as soon as the youth is admitted to the facility. Healthcare staff is responsible for the notification to the DHA regards to serious or chronic conditions. Referrals are documented in the IHCR and on the FEPHS form.

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 total of five Individual Healthcare Records (IHCR) were reviewed for completion of a Health-Related History (HRH) form for each youth admitted into the program. Each of the HRH reviewed, were completed at the time of the youths' admission to the program. All five IHCR reviewed, had an indication the HRH was completed by a registered nurse (RN). There was also evidence the designated health authority (DHA) reviewed and signed the HRH. Each HRH was completed before or at the same time as the Comprehensive Physical Assessment. The on-site nursing staff was interviewed. Nursing staff stated the HRH is completed by the nurse or practitioner within seven days of the admission date.

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.	

A total of five Individual Healthcare Records (IHCR) were reviewed for completion of the Comprehensive Physical Assessment (CPA). The program utilizes the Department's CPA form. All five IHCR reviewed, had a current CPA on file at the time of admission. The program's designated health authority (DHA) completed all five CPAs reviewed. The medical grade for each youth was indicated on their respective CPAs. The CPA was completed in accordance with Florida Administrative Rule requirements. All sections of the CPA were marked with an 'O'. Parts of the exam which were refused by the youth, the clinician wrote; "Youth Refused". Each youth signed on the CPA, indicating they had refused a portion of the CPA examination, in addition, completed a refusal form. Each of the five IHCRs had the Department's Problem List updated as required. Each of the five IHCRs contained evidence the results of the Tuberculosis Screening Test (TST), were documented within the last year, on both the CPA and the Infectious and Communicable Disease (ICD) forms. Each of the five youth were assessed prior to placement in general population. The program has written facility operating procedures (FOP), which provides for appropriate documentation practices, when any part of the exam is not conducted and/or is refused by the youth. Each applicable youths' refusal form(s) were

reviewed and indicated having been completed, or documentation provided for, when deferred by practitioner after review of the HRH form, for those part(s) of the exam which were not performed. A review of each CPA for all youth reviewed were sampled. Each applicable Youth Refusal Forms was reviewed. A review of applicable Chronological Progress notes for Focused Evaluations were reviewed. A review of the Facility Entry Physical Health Screening form, the CPA, and/or Infectious and Communicable Disease (ICD) form for documentation of a completed TST results/chest x-ray results were conducted. There were no youth applicable for completion of chest x-ray results. There were no youth applicable for TB refusal. The programs written FOP is in compliance with the Centers for Disease Control and Prevention new 2006 recommendations and Occupational Safety and Health Standards (OSHA). A review of the programs FOP for Tuberculosis Screening was conducted. The on-site nursing staff was interviewed. Nursing staff stated, the DHA completes a new CPA yearly for youth with chronic conditions with a medical grade of two and above. For those youth with medical grade one, a new CPA is completed no more than every two years. Nursing staff stated the process for TB screening is to be completed within seventy-two hours of admission. There should be at least one TB test documented in the healthcare record within a year. Positive test shall be reported to the DHA for a chest x-ray for further evaluation.

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

A total of five Individual Healthcare Records (IHCR) were reviewed for sexually transmitted infections (STI) and human immunodeficiency virus (HIV) screening. Each of the IHCRs reviewed, were clinically screened and evaluated for STIs. When further evaluation was needed, youth were referred to the program's designated health authority (DHA). Each of the five-youth reviewed, had testing ordered and it was performed as directed by the DHA. Results for individual screenings were documented on the Infectious and Communicable Diseases (ICD) form (excluding HIV results) and filed in each youth's IHCR. None of the records reviewed had evidence the youth were out of the Department's physical custody, which would have required a re-screening. All referrals were documented on the STI screening forms. There was evidence in the IHCRs reviewed, each youth was offered counseling, testing, and treatment for HIV. Each of the five applicable IHCRs reviewed, had documentation youth received HIV testing. A certified HIV counselor conducted the testing for each of the five youth IHCRs reviewed. Documented consent from the youth was obtained in each of the five youth IHCRs reviewed. Documentation of pre and post-test counseling was documented on the IHCR for each of the five-youth reviewed. HIV results are filed confidentially in a sealed envelope marked 'confidential', consistent with Florida Statute 381.004. There was no indication of a youth's HIV status having been included on the program's internal alert system. None of the youth reviewed, had a consent/release form, stating those individuals to whom this information should be released to. The OASIS Florida program provides HIV pre and post-test and counseling services; certification expires August 31, 2020. A copy of the Department of Health (DOH) 501 certification was provided for during the annual compliance review. Five youth were interviewed, each reported they were able to request an HIV/Aids test. The on-site nursing staff was interviewed. Nursing staff stated, upon admission to the facility all youth are screened for STIs. If the youth needs treatment, the DHA is notified for further orders. If screening indicates a need for further evaluation, a call is placed to the DHA for an order for further evaluation immediately. STI screenings, evaluations, referrals, and testing are documented on the progress notes, doctors order form, and on the ICD form. Youth can request HIV counseling and testing at any time. After a request is made by a youth, counseling and testing is performed. An outside

provider conducts counseling and the HIV testing. Youth can request HIV counseling and testing services at any time. An outside provider provides such services monthly. If the request is emergent, the DHA is notified for further orders for testing. The process is documented in the youth's education record but not the results. Test results are left in the chart in a sealed envelope.

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 total of five Individual Healthcare Records (IHCR) were reviewed for Sick Call Process (request/complaints). None of the IHCRs presented with similar sick call complaint three or more times within a two-week period. None of the youth complained of any severe pain with which staff was unfamiliar. Each youth reviewed, completed a Sick Call Request form, which was placed in a secure location inaccessible to youth, and then provided to the nurse. Each of the five IHCRs reviewed, contained a completed Sick Call Request form and was filed with the progress notes in the IHCR, in reverse chronological order. None of the sixteen Sick Call Request forms reviewed were conducted by a licensed practical nurse (LPN). There were no reported instances of youth who were in restricted housing. When there is not a licensed nurse on-site, the program shall have procedures whereby the shift supervisor reviews all Sick Call Request forms as soon as possible and within four hours after the request is submitted; pursuant to the program's written facility operating procedures, the program will address any sick calls (when nursing staff not on-site) within two hours. Sick Call is conducted daily; seven days a week. Each of the Sick Call Request forms or progress notes reviewed, were documented in accordance with Health Services Rule 63M-2. Each of the sixteen sick calls were individually documented on the Sick Call Index. Each of the sixteen sick calls were individually documented on the Sick Call Referral Log. Each of the completed Sick Call Request forms were file with the progress notes in the IHCR, in reverse chronological order. The program has regularly scheduled sick call hours posted. Sick Call is seven days a week, conducted at 7:00 a.m. on weekdays and 8:45 a.m. on weekends. The registered nurses (RN), provides sick call services. A licensed nurse conducts sick call. Non-licensed protocols are in place for established process for sick call when the licensed nurse in not on-site. Youth privacy is ensured during sick call encounters. Sick call availability and request forms are available to youth. An exam table and equipment is used to perform sick call. A sick call was observed while on-site during the annual compliance review. Verbal permission was obtained from the youth and nurse prior to start of sick call. The youth was observed brought into the nurse's station by direct care staff. The medical provider identified themselves and stated why the youth was there. The youth was not asked to initial/sign they were seen prior to the examination. The youth signed after completion of the examination on the Sick Call form. The youth was seen in a private area with no other youth present to hear or see the examination. The youth was examined by the licensed person. A direct care staff was present during the examination; they were not directly in the room; they stood outside the nurse's station. This allowed medical staff to maintain privacy. Five staff were interviewed, each staff reported, the nurse responds to sick calls. All five staff report the nurse conducts sick call. Five youth were interviewed, each youth stated they see a nurse within one day after making a Sick Call Request. The on-site nursing staff was interviewed. Nursing staff stated, health complaints are filled out on a Sick Call form. Youth must be seen within four hours upon request. Sick calls are conducted by nurses. RN

staff only conducts sick calls at the facility. Sick call is conducted in the nurse's station. Sick calls are completed daily. Sick calls are conducted within four hours upon request. If a direct care staff answers a sick call, nursing staff must follow up upon the return to the facility. If a youth presents with a sick call three times within a two-week period, they must be referred to the DHA for follow up treatment.

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 total of five Individual Healthcare Records (IHCR) were reviewed for episodic/first aid and emergency care. Only three of the five IHCRs reviewed had an indication the youth required on-site first aid or episodic care. Date and time of episodic care was documented for each of the three applicable youth reviewed. None of the three-youth reviewed required non-healthcare staff intervention; each of the three youth when identified with an episodic and or emergency care need, were brought to the nurse's station for medical evaluation. All three youth were provided care on-site by licensed healthcare staff. The licensed healthcare staff documented the care in problem-oriented, Subjective Objective Assessment and Plan elements (SOAP). The program has written facility operating procedures (FOP) addressing episodic and emergency care procedures. Emergency medical and dental care, including emergency medical services (EMS) are available twenty-four hours daily. Locations of first aid kits, wire cutters, and knife-for-life were observed. The four first aid kits were located within the program's master control, dietary, and in each of the two program vehicles. The two suicide response kits were located both within the program's master control area. First aid kits are fully stocked with designated health authority (DHA) approved contents; each kit was reviewed during the annual compliance reviewed. First aid kits are fully stocked with designated health authority (DHA) approved contents for transportation; each kit was reviewed during the annual compliance reviewed. Healthcare staff at a minimum check first aid kits monthly. Healthcare staff have an individual tracking sheet, where they document first aid checks are complete. In addition, a separate check box is provided for on each kit, indicating the specific kit was checked. The medical department maintains an episodic care log which documents all instances of first aid/emergency care. A review of the episodic care log for past six-months was reviewed and compared with all on/off events from the five IHCRs sampled. A review of progress notes and non-healthcare staff forms for each on/off-site event were reviewed from the five IHCRs sampled; there were no non-healthcare forms required, however, applicable progress notes were present. The program has an automated external defibrillator (AED). There is an instruction guide/binder for the AED. The AED is located within master control. The AED procedures are located within master control. The healthcare staff check to ensure the AED batteries and pads are operable. On-site nursing staff checked the expiration dates in front of the Monitoring and Quality Improvement (MQI) regional monitor during the annual compliance review. On-site nursing staff conducted a self-test of the AED in front of the MQI regional monitor during the annual compliance review. The AED batteries expire September 2022. The last date the AED batteries were changed was in 2017. The AED pads expire April 2021. The last date the AED pads were changed was in 2017. There was no observed install date on the AED for either the batteries or pads. Copies of all AED checks since last MQI annual compliance review was completed. Copies of the medical drills were made. Mock emergency medical drills are conducted at least quarterly on each shift. Mock emergency drills included a demonstration of cardiopulmonary resuscitation (CPR) and AED annually. Emergency drills, both announced and or unannounced, are held for each shift, on a quarterly basis at a minimum, and simulate an episodic care event, which calls for immediate first aid and or administration of CPR techniques and the initiation of the emergency

procedures to follow when life-threatening emergency does occur. The program has three operating shifts. Each of the three shifts conducted mock emergency drills. Shift one completed six drills spanning from June 2019 through November 2019. Shift two completed eight drills spanning from June 2019 through November 2019. Shift three completed six drills spanning from June 2019 through November 2019. Copies of all medical drills were made. A list of emergency numbers (including poison control center) were posted in master control. The emergency numbers were inaccessible to youth. When a youth requires the use of an epinephrine auto injector, all health care and direct care staff (at the supervisory level) are appropriately trained on the administration of the epinephrine auto injector and shall administer the epinephrine auto injector when indicated. The program has an appropriately trained RN, who trains other healthcare staff and non-healthcare staff on the use of the epinephrine auto injector. Confirmation of staff training requirements was conducted with team member assigned to training indicators. Five youth were interviewed, each youth was asked if they can see a dentist if they have tooth pain. Four out of the five youth indicated yes, they could, one youth replied no. All five-youth confirmed they can see a doctor if needed. Five staff were interviewed, each agreed they are personally allowed to call 9-1-1 if a youth has a medical emergency. The on-site nursing staff was interviewed. Nursing staff stated, episodic care is documented in the healthcare record in the progress notes and then placed in the episodic care log book. All the non-healthcare staff is CPR/First Aid certified and documentation of care should be on the Department's Report of On-Site Healthcare by Non-Healthcare Staff form. There is a transportation log located in medical for all medical transports; this is how they track youth who are sent off-site for emergency care. The program has an AED, which is in the control room. AED procedures are in the AED bag, in the control room. The health services administrator checks to ensure the AED batteries and pads are operable. The AED batteries expire in 2022. The AED pads expire in 2022. The last date the AED batteries were changed in 2017. The last date the AED pads were changed in 2017. Drills are conducted monthly on all three shifts. CPR is to be reviewed at least yearly for all employees. Medical drills are conducted monthly on all three shifts. A transportation log is in place for those youth sent off site. The off-site care is also documented in the progress notes in the IHCR.

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.	

A total of five Individual Healthcare Records (IHCR) were reviewed for off-site care/referrals. Two IHCRs reviewed were applicable for the youth requiring off-site care. A third youth was scheduled to be off-site for an appointment the week after the annual compliance review. Each of the IHCRs contained documentation of parental notifications. Additionally, the Summary of Off-Site Care form was utilized and filed within the IHCR. Discharge and other documents are filed in the IHCR. The designated health authority (DHA) reviewed and signed/initialed all applicable off-site care findings, instructions, and information. None of the youth reviewed required follow-up testing or appointments. The on-site nursing staff was interviewed. Nursing staff stated, orders are reviewed by the nurse and orders are then reviewed with DHA by phone or on-site if the DHA is in the building. All Off-Site Care forms for youth are stored in the DHA sign off binder for review and then filed in the IHCR. An appointment book and calendar are utilized to track follow-up testing, referrals, and appointments.

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.	

A total of five Individual Healthcare Records (IHCR) were reviewed for chronic conditions/ periodic evaluations. Each of the five-youth reviewed were identified on the Facility Entry Physical Health Screening (FEPHS) as possessing a current chronic condition. None were applicable for having a communicable disease. All five-youth reviewed, were taking a prescribed medication on an on-going basis. Two of the five youth reviewed were applicable for undergoing treatment for a physical health condition, which included body mass index (BMI) greater than thirty. Each of the five-youth reviewed, were classified with a medical grade of two or higher. None of the youth were identified as being pregnant. Each of the five youth meet criteria for being placed on the program's chronic conditions list. All five youth are in receipt of periodic evaluations at no greater than three-month intervals. Each of the five youth with a chronic condition have received a specialized treatment plan. None of the youth reviewed are taking anti-tuberculous medication. Each of the five youth are tracked for periodic evaluations, which are maintained within the youth's IHCR. All the youth were in receipt of periodic evaluations conducted on-site, which was documented in the youth's IHCR chronological progress notes. Each of the youth's treatment orders are written so they are clearly distinguishable for clinical staff. Only one youth was applicable for an evaluation off-site, which was documented on the Summary of Off-site Care form and filed with the youth's IHCR chronological progress notes. Subsequently, the designated health authority (DHA), also conducted a follow-up after the off-site evaluation and signed off on documents. There were no indications of lapses in care or missed periodic evaluations. For each of the reviewed youth, the Department's Problem List was updated in accordance with the Health Services Rule 63-M. A review of youth's progress note for documentation of each periodic evaluation was conducted with no issues. The DHA was interviewed and stated, all periodic evaluations are placed on a tracker. Periodic evaluations are conducted every ninety days or more frequently, if needed, for youth with chronic conditions. The on-site nursing staff was interviewed. Nursing staff stated, youth with chronic conditions are seen by the DHA for periodic evaluation in less than three months.

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.	

A total of five Individual Healthcare Records (IHCR) were reviewed for medication management. Four of the five youth reviewed were applicable for taking medication at admission. Each of these youth, the medication was verified prior to being accepted to the program. Prescription verification was documented in the chronological progress notes in each of the five records utilizing the medication verification checklist. For each youth, the designated health authority (DHA) was contacted to obtain the order to resume the specified medications youth were prescribed prior to admission. All medications have a current, valid order and were given pursuant to current prescription in each of the youth reviewed. In each of the IHCRs reviewed, for mediations which are continued, discontinued, changed, or new ones are ordered, the DHA placed an on the Practitioner Order form. None of the youth were applicable for having been placed in restricted housing. Each of the youth had over-the-counter medication not listed on the Authority for Evaluation and Treatment (AET) form. The medications were administered according to approved protocols and the written practitioner's order. The program utilizes the

standard Department Medication Administration Record (MAR). Each of the five youth's MARs clearly indicated medication start and stop dates. Staff initial each administered medication entry. Each of the five youth, for a period of up to six months, MARs were reviewed. There were no undocumented explanation for lapses or errors in medication administration. Nursing staff documented weekly side-effect monitoring on the MAR for each of the five-youth reviewed. The Six Rights of Medication Delivery/Administration were maintained by licensed staff administering medication. Only one applicable youth out of the five reviewed, contained evidence the youth refused medication. The refusals were clearly documented on the MAR and refusal forms completed and signed by the youth. A review of each youth's Facility Entry Physical Health Screening (FEPHS) form and progress notes was conducted to confirm if youth was admitted with medication and subsequent verification; no noted issues. A review of progress notes for each youth, for notification to the DHA and parent/guardian when applicable was conducted; no issues. A review of each of the five youth's progress notes and/or DHA order section to verify medication regimen was conducted; no noted issues. The medical clinic has all medications in a separate, secure (locked) areas, which are inaccessible to youth. All of the program's non-controlled medications (prescribed and over-the-counter) are stored in a separate, secure, locked area, which are inaccessible to youth. The program has narcotics and other controlled medications, which are stored at a minimum behind two locks. Observed locked in the medication cart in a locked box, located behind a locked door within the locked medical clinic. Observations of the oral medications indicated they are not stored with injectable or topical medications. Each of the program's medications requiring refrigeration are stored in a secured refrigerator, which is used for medication only. Observations of the program's syringes and sharps are secured. The medical clinic medication cart was observed to be clean/organized and stock items are separate from youth specific medications. The program has a written agreement with a pharmacy provider for the disposal and destruction of expired and/or discontinued medications. A review of the program's written policy and corresponding documentation was conducted for the disposal of medication. An observation for the area designated to store youth medication was conducted; no issues. An observation of one medication pass, was conducted. Five youth were interviewed, four out of the five youth identified either the doctor or nurse as who gives them their medication. One youth stated he does not take medication. Five staff were interviewed, each of the staff agreed nursing staff provide medication to youth. Two out of the five staff also provided, certified staff who are approved, can give medications, when the nurse is not on-site. The on-site nursing staff was interviewed. Nursing staff stated, the process for nursing staff to verify a youth's medication regimen; a call is placed to the DHA or psychiatrist for orders to continue medication once the prescription verification is complete and reviewed. Medication is reviewed by nursing staff only. In addition, the standard Department MAR is utilized at the program. When the program does not have twenty-four hour nursing staff, non-healthcare staff can provide OTC medication to youth if they are medication certified.

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.	

All medical equipment classified as sharps (e.g., syringes, needles, scissors, and suture removal kits) are secured and inventoried by using a perpetual inventory descending count as each sharp is utilized and disposed. All medications are identified and secured in a locked area designated for storage of medications. Different medication forms (e.g., injectable, topicals, drops, liquids) are separated. All controlled substances have a perpetual inventory and are stored separately from other medications. In addition, controlled substances are maintained

behind two locks with two separate key access located in the medical department. The program has a process for the destruction and disposal or return of expired or discontinued medications. A perpetual and a weekly inventory of all sharps and stock over-the-counter (OTC) medications is conducted. A shift-to-shift inventory count of all controlled substances is documented on the youth's individualized Controlled Medication Inventory Record. A third shift to first shift count, of controlled medications is conducted prior to medical staff beginning medication pass. A strict control and accountability of the running balance for each controlled substance is maintained. Each supervisory level, non-health care staff is trained in the delivery and oversight of medication self-administration. The total number of pills, tablets, or dosages remaining after each administered dosage is documented on the youth's Individualized Controlled Medication Inventory Record received with the medicine from the pharmacy or the Department form. An observation of a count completed by the nurse was conducted. The count matched ending inventory numbers. An inventory of two youth medications was conducted (one was a narcotic or controlled medication); no issues. An inventory of three OTC medications was conducted; no issues. An inventory of three sharps was conducted; no issues. A reporting criteria and procedures for inventory discrepancies are in place. A review of program inventories for the past six months along with the area designated to store sharps was conducted; no issues. All medications within the program are in a separate, secure (locked) areas inaccessible to youth. All non-controlled medications (prescribed and over-the-counter) are stored in a separate, secure, locked area inaccessible to youth. Narcotics and other controlled medications are stored behind two locks; locked in the medication cart in a locked box, located behind a locked door within the locked medical clinic. There were no oral medications stored with injectable or topical medications. Medications requiring refrigeration are stored in a secured refrigerator, which is used for medication only. Syringes and sharps are secured; no issues. Medication cart is clean/organized and stock items are separate from youth specific medications. The program has a written agreement with a pharmacy provider for the disposal and destruction of expired and/or discontinued medications. A review of the program's written policy and corresponding documentation was conducted for the disposal of medication. All medications are identified and secured in the locked area designated for storage, which was locked and inaccessible to youth. Controlled substances are maintained behind two locks; locked in the medication cart in a locked box, located behind a locked door within the locked medical clinic. Different medications are separated (e.g. Oral medications are not stored with injectable or topical medications). All medical equipment classified as sharps are secured and inventoried weekly and by using a routine perpetual inventory by descending count as each sharp is utilized and disposed. An observation was made of the area designated to store youth medication; no issues. The on-site nursing staff was interviewed. Nursing staff stated, medications are stored in locked areas and controlled medications are stored in the cart in a locked box behind two locked doors. Medications are inventoried weekly and perpetually. Medications are destroyed with a witness in a disposal bottle and controlled medication is witnessed and destroyed with the pharmacy consultant. Controlled medication is kept in a locked box inside the cart behind two locked doors. A current agreement/contract with consultant pharmacist indicates they are on-site monthly. A consultant pharmacy license is available.

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

The program has a written infection control procedure in place to include the prevention, containment, treatment, and reporting requirements related to infectious diseases, as per Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control (CDC) guidelines. The infection control procedures included the following: common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, and viral or bacterial infectious diseases. Also, tuberculosis, hepatitis A, B, and C, along with HIV infectious diseases caused by blood-borne pathogens. In addition, outbreaks or epidemics caused by any other infectious agent, whether spread directly or indirectly. Also included, outbreaks of pediculosis (lice) and/or scabies, methicillin-resistant staphylococcus aureus (MRSA), and other emerging antibiotic-resistant micro-organisms. The procedures addressed, bio-terrorist agents, chemical exposures in the workplace, hepatitis B immunization available for staff, and staff access to protective equipment. There was documentation standard universal precautions are followed by all staff. There we no instances in which the local county health department, CDC, and/or Central Communications Center (CCC) should have been notified of an infectious disease. The program has a comprehensive process for needle stick post-exposure evaluation. The clinical manager or designee will complete and file all reports regarding infectious diseases for youth and staff who have experienced a facility or occupational exposure. The program has an Exposure Control Plan which is written in accordance with OSHA standards. The Exposure Control Plan is available to all staff, located in medical and master control. The Exposure Control Plan is signed annually by program administration. The Exposure Control Plan includes Risk Assessment and Methods of Compliance. The Exposure Control Plan includes a comprehensive process in place for needle stick post-exposure evaluation. The program has been in operation going on three years and have not experienced any issues, however, records will be maintained confidentially for a ten-year period. There were no instances of three or more cases of any reportable infectious diseases needed to be reported to the local county health department and/or CDC. There were no instances involving the quarantining or hospitalization of at least ten percent of the total population of youth or staff, or six individuals. The facility administrator was interviewed. The exposure control plan is located in nursing and master control and is reviewed at least annually. The on-site nursing staff was interviewed, and they agree a copy of the Exposure Control Plan is available to them. Nursing conducts infection control training for staff upon hire and annually. Infection control training is provided by nursing upon the youth's admission to the facility. Nursing is responsible for providing Exposure Control Plan; upon hire and 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.	

The program consists of an all-male population; therefore, this indicator will be rated non-applicable.

Standard 5: Safety and Security

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

The supervision of youth was observed each day during the annual compliance review. The program's staff ratio is one to eight youth during the day-time hours and one to twelve youth during the night-time hours. The program's direct care staff workers are responsible for direct and active supervision of youth, described as sight and sound supervision by the staff. Staff stated their responsibilities require active knowledge of the whereabouts of each youth assigned to them as well as observing their behavior. The daily schedule is posted in the living area and contained a full schedule of activities. When staff were asked what to do if a formal head count could not be reconciled, they replied all movement is stopped, and counts are reconducted reconciling the correct number of youths. Random observations were made during the day by inquiring staff as to how many youths were in their supervision, and then counting those youth. All staff to youth ratios observed were found to be within the standards compliance.

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 maintains a written policy and procedures pertaining to the behavior management system (BMS). The program's BMS is found in the staff and youth handbooks, and posted in various program areas. The youth handbook also contains what is considered positive and negative consequences for behaviors. There has been no change in the BMS since the last annual compliance review. During the annual compliance review, observations of the BMS included daily youth and staff interactions. All interactions were appropriate and within the guidelines of the BMS. Five interviewed staff all had working knowledge of the BMS. Staff were able to confirm rewards were given to the youth for good behavior which included nightly incentives, gotchas, video games, and Big Friday where the youth can receive special food. Youth which displayed negative behaviors have such things as television, video games and iPod taken away. Five youth were interviewed. All five were able to articulate the BMS and how it works, and how to process through the different levels. The youth described losing points, not being able to attend outings, and privilege restrictions as the results for negative behaviors. The facility administrator was interviewed concerning the BMS. He was able to detail the program's level system and discuss various rewards and privileges youth may earn, as well as consequences for inappropriate behaviors exhibited. The facility administrator reported the use of four to one ratio for positive to negative consequences, stating the treatment team ensures positive reinforcers are applied by points, awards, and nightly incentives. The treatment team monitors consequences through team meetings. In addition, he indicated implementation of the

BMS is discussed during all staff monthly meetings, shift supervisor meetings, and staff evaluations.

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 in place providing for feedback pertaining to the implementation of the behavior management system (BMS) by staff. The program reported they do not utilize room restrictions. The program's BMS includes a process wherein staff explain to the youth the reason for any sanction imposed prior to the end of the staff member's workday. The youth is also given the opportunity to explain his behavior, and staff and the youth discuss the behavior's impact on others, as well as alternative acceptable behaviors. All youth care specialists are trained and monitored to ensure they are providing a safe, secure environment through the implementation of the BMS. Five staff training records were reviewed for pre-service training requirements, and all contained records of staff receiving training on the implementation of the BMS. Staff were trained in the jointly combined BMS plan to include the use of BMS during school. The program's BMS does not include increased length of stay, denial of youth basic rights, promotion of group punishment, punishment by other youth, and/or disciplinary confinement. Consequences are reviewed with the youth on a daily basis before the end of the shift from which the consequence was given. A review of the provider's contractual agreement ensured all required parties were involved in the development, implementation, and on-going maintenance of the BMS. A review of position descriptions was completed to ensure the proper implementation of BMS was identified within for those staff whose job functions included this BMS implantation. Five interviewed youth stated all youth are treated equally. Youth denied they are allowed to punish other youth. Five interviewed staff explained they immediately notify youth of any consequences they may receive as a result of inappropriate behavior exhibited. All five staff reported they receive feedback from supervisors for their implementation of the BMS.

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

The program has a total of thirty-two cameras with thirty operational at the time of the annual compliance review. A work order has been placed for the repair of the two cameras which are inoperable. Video recordings are stored for thirty days. A review of six evening/night shifts, including all three shifts and a weekend day, were conducted through the video recording

system and compared to the written documentation to ensure the accuracy of the checks. All checks were found to be in compliance and conducted within the required ten-minute timeframe. Five interviewed staff all reported room checks are to be completed every ten minutes.

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

The program has a written policy and procedures to determine youth census, counts, and youth tracking. The program utilizes only one logbook which is maintained in master control. A review of the logbook was conducted and found counts are entered at the beginning of each shift, after all activities and/or movements, and as required during emergency situations. After reviewing the logbook, it was determined the total daily census, head counts, youth movements, new admissions, releases, transfers and youth who are temporally away from the program were captured in the logbook. Random counts were conducted with no noted issues. All youth were accounted for and staff interviewed stated if all youth are not accounted for during a count all movement is stopped and the count reconducted to ensure all youth are located. Five interviewed staff were familiar with the formal count process for youth. Staff reported in the event a discrepancy occurs within a head count, all youth movement is stopped, and a recount occurs.

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 only one logbook which is maintained in master control. Logbooks were reviewed for the last six months prior to the review. All logbooks were bound with numbered pages, there were no missing pages and the books were not falling apart. Entries were made in ink and there were no erasures or white-out areas found. All entries contained the date and time, the name of the staff and youth involved, and a brief description of the event as well as the names of the staff making the entry. The logbook contains documentation of emergency situations, incidents, special instructions for the supervision and monitoring of youth, population counts and the beginning and end of each shift, and any other counts conducted. Perimeter or other security checks conducted, and transports with details are maintained in the logbook. Admissions, releases, information relating to escapes or attempted escapes and any incidents

reported to the Florida Abuse Hotline and/or the Central Communications Center are logged in the facility master logbook. A shift debriefing is maintained both in master control and on each module.

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

The program has a policy and procedures in place to govern the control and use of keys. The procedures include a system of key assignment and usage, to include restricted keys. In addition, the policy includes inventory and daily tracking of keys, secure storage of keys, and the procedure to address lost and damaged keys. Personal keys are turned in upon arrival in exchange for facility keys. Personal keys can only be attained by the return of the facility keys. Staff assigned keys are inventoried by each shift to ensure accuracy. All keys were maintained on rings and matched on a key inventory form. Restricted keys consist of case managers, dietary and therapist, these keys are stored in a separate lock box in master control. Medical, assistant facility administrators, unit managers, and clinical director keys are maintained in a coded lock box in master control. Unrestricted keys are stored in a lock box in master control which consists of direct care staff, education, recreation yard, supervisors, and personal keys. All keys are securely stored. The master control officer was interviewed and reported permanent issued keys are secured in a lock box. The key sign in/out log is maintained daily. A sampling of three random staff was done to compare their keys with the key inventory log. All three samples matched the log as required. Key and radio control logs are maintained on a daily basis. Damaged keys are logged in the logbook and a Tool and Key Issue form is completed for maintenance to replace. There have been no lost or missing keys within the scope of the annual compliance review. The program has a process for reporting lost or missing keys within their Key Control policy. Five interviewed staff were all able to summarize the program's key control process. Staff also indicated in the event a key is missing, the program is searched until they are recovered. If they are not found, a report to the Central Communications Center (CCC) may be required. In the event a key is damaged, staff reported the supervisor and maintenance staff is notified.

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 written policy and procedures to address contraband introduction into the facility. The youth handbook outlines a list of items considered to be contraband. All youth are given a copy of the handbook which contains a summary of what is considered contraband and the consequences for being found with it. Anyone entering the facility is wanded by a staff member. This process was observed during each day of the annual compliance review. The program has a developed system to implement the prevention of contraband. Their policy delineates what is considered contraband. It is the responsibility of every staff to assist in the prevention of contraband. Staff should utilize trauma informed practices, effective communication to alleviate stress, conduct random youth and room searches, contact law enforcement for illegal contraband. All staff and youth are given a list of all items considered contraband. A review of items considered contraband determined the programs prohibited personal cell phones, equipment, and electronic devices. Consequences include the contraband being discarded, returned to original owner, and mailed to youth's home or stored and returned to youth upon their release date. Illegal contraband is turned over to law enforcement. According to program policy, any staff who is found in possession of contraband in the program will be subject to disciplinary action up to and including dismissal. A review of the logbook, incident reports, and search reports was done and determined the program conducts searches for contraband as required. The facility administrator was interviewed and stated all contraband is confiscated and turned into the program administration and maintained in a secure safe. Any illegal contraband is turned over to law enforcement.

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 and after groups, and before and after movement from one activity to another. There were no transports during this annual compliance review available for observation. All searches were observed conducted by the appropriate staff and gender. Prior to conducting the search staff was observed explaining the purpose of the search.

Staff was not observed using unnecessary force or rhetoric defacing the youth dignity and respect. Searches and full body visual searches were based on the Protective Action Response (PAR) training manual. Observation include appropriate searches completed upon each movement of the youth from one area of the program to the next. This was observed each day during the annual compliance review. Five interviewed staff all reported youth are searched after each movement throughout program areas. Five interviewed youth reported searches occur when returning from off-campus activities, after outdoor activities, after meals, and during general youth 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 on-site for the transportation of youth. Both vehicles have had an annual inspection and maintenance records were found to be in compliance with the standards. There were no transports scheduled for the week of the annual compliance review; however, transportation staff and youth were interviewed to confirm their understanding of consistency with seatbelt usage. A vehicle check was conducted during the annual compliance review in which two vehicles were found unsecured. When asked, the supervisor stated they had arrived after his morning perimeter check was conducted. Both vehicles contained fire extinguishers, first aid kits (available in master control for transport), seat belt cutter, and window punches. Each vehicle contained the appropriate number of seat belts. Youth are not attached to any part of the vehicle by any other means than the proper use of a seatbelt. Doors to the vans cannot be opened from the inside. One of the two vehicles contained a safety screen.

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.	

There were no transports available for observation during this annual compliance review. The program maintains a policy and procedures outlining the proper transportation of youth. Transportation of youth is at a one to five staff to youth ratio. At least two staff are required if five or less youth are being transported. A transport cell phone and/or radio is available to staff. If the transport is across the street to the juvenile detention center, a radio is utilized. One staff of the same gender as the youth is maintained on all transports. The program maintains two vehicles equipped properly for all transports. A program vehicle sign-in and out log is maintained. A random check of personal vehicles was conducted to ensure all vehicles are kept locked in the parking lot. A staff driver list was provided in which all drivers records were checked for accuracy. There were no discrepancies found. Five interviewed staff reported they are provided communication devices when transporting youth. All five staff reported they are not allowed to transport youth in personal vehicles.

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

The program has a policy and procedures which outlines the weekly Safety and Security Audits. The policy indicates who is responsible for conducting the weekly audits and the implementation of corrective actions as deemed necessary by deficiencies found during any internal and/or external review, audit, or inspection. Sample weekly safety and security audit documents were reviewed and found to meet all requirements. Audits are conducted on a weekly basis. All areas of the program are reviewed during the weekly audit and are emailed to the Department of Juvenile Justice's residential safety and security monitor.

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 maintains a written policy and procedures which addresses the issuance, inventory and control of all tools. The procedure outlines the process for missing and/or lost tools. There were no reports of missing or lost tools during the scope of the annual compliance review. All tools are marked with an identifying number. The maintenance person conducts a daily inventory of all tools with sharp edges and a monthly inventory of all other tools. The perpetual inventory includes items of tools signing in and out. Kitchen tools were also observed and are inventoried daily. Kitchen knives were secured in a locked box. Any dysfunctional tools are disposed of and replaced as needed. The program prohibits machetes, bowie knives, or other long blade knives. All staff were found to have completed training for the intended and safe use of tools as part of their pre-service training requirements. All tools observed were accounted for based on inventories reviewed. Youth do not handle tools or are allowed in the area where tools are stored. Five interviewed youth all reported they have only utilized mops, brooms, and scrub brushes in the program.

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 in place for the issuance of tools to youth and staff which includes an assessment to determine a youth's risk to self and others. The program only allows youth utilization of Class B tools, which include cleaning items such as mops and brooms. The program maintains one to five staff to youth ratio for activities involving tools, and one to three during any disciplinary work projects. Risk assessments for youth were reviewed to ensure they have been completed prior to youth using any tools. Five staff were interviewed concerning youth tool usage. Two reported youth do not use any tools. Three staff reported they use only mops and brooms. Five interviewed youth all reported they have only utilized mops, brooms, and scrub brushes in the program.

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 providing contractors with a notice of tool/equipment instructions prior to any work occurring, restricting only the tools which are deemed necessary. Contractor agreement forms were reviewed and found all tools were checked upon arrival and again at departure. During the work process, all youth are restricted from the area. Sign-in sheets were reviewed and found to be completed correctly and signed by program staff. A review of project invoices was completed and determined the date the project was being completed matched the sign-in sheets of the outside technicians or workers. Personal cell phones are prohibited from entering the secure program area. Only the program director can approve cell phones or other devices.

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

The program maintains a policy and procedure to provide for the safety and security of both staff and youth. Drills were consistent with the Continuity of Operations Plan (COOP). All drills contained the type of drill, date and time, participants, and a brief scenario, including findings, and recommendations. Fire drills were conducted on a monthly basis with no exceptions. Emergency drills were also conducted to include disasters and bomb threats. Evacuation and egress routes were posted throughout the facility. All fire extinguishers were inspected annually. Five interviewed youth all expressed they have been informed what to do in the event of a fire. All stated they have participated in drills at least monthly. Five interviewed staff reported they have participated in fire drills. Staff also indicated they have participated in other drills such as weather, bomb threat, chemical spill, suicide and medical, and escape drills. The facility administrator reported fire drills, and medical drills are done monthly. Suicide and disaster drills are completed 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 policy and procedures addressing the Continuity of Operations Plan (COOP). The plan was reviewed, approved, and signed by the regional director on March 19, 2019. The COOP is located in the master control room available to staff, and in the facility. The facility administrator was interviewed and also confirmed the plan is maintained in master control, and all staff have access to the plan. The program's disaster plan and the COOP are combined into one plan which addresses alternative housing plans approved by Department's

regional director/designee. The COOP includes fire and fire prevention and evacuation, severe weather, program disturbances, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, equipment and supplies needed, information about youth, alternative housing arrangements, provisions for continuity of care and custody of the youth, and provisions for public protection. The program maintains all required critical identifying information for each youth in an administrative hard-copy file which is easily accessible and mobile in the event of an emergency situation resulting in the program relocating quickly, or in the event the information may not be obtained electronically.

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 maintains a written policy and procedures addressing flammable, poisonous, and toxic materials. These materials are stored in secured places throughout the facility, such as outside storage shed, outside closet, secured cabinets in the kitchen area and a cabinet in master control. Flammable materials such as diesel, gas, or pesticides are kept outside in the metal storage building, the only individuals allowed to handle these materials is maintenance and the facility administrator. Upon observations made during the annual compliance review, inventories for flammable, poisonous, and toxic items and materials at the program are all accounted for. There were no items on-site not on the inventory. The Safety Data Sheets (SDS) were all present and determined there is an SDS for all materials. The storage area restrict access to only appropriate staff. The program policy indicates a listing of facility positions authorized to handle these items.

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

The program maintains strict control of flammable, poisonous, and toxic items and materials. Policy and procedures prohibit youth from handling flammable, poisonous, and toxic items and/or materials. All items are strictly maintained outside the secure buildings and is inaccessible to youth. No youth were observed handling chemicals. Youth interviews revealed they are not prohibited to handle any chemicals. Five youth interviews were conducted. One youth reported using window or toilet cleaner but stated he did not handle the chemical directly. He stated staff spray the chemical and the youth wipes it off. The remaining four youth stated they do not use any chemicals at the program.

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

The program has a written policy and procedures in place concerning the disposal of flammable, toxic, caustic, and poisonous items. The maintenance staff is responsible for the disposal of hazardous waste. Kitchen grease is disposed of in the grease trap located outside the secure area and disposed of by an outside contracted entity. Kitchen liquid waste, except for grease which is disposed of through the kitchen drains and goes into the grease trap. Maintenance staff was interviewed and stated all corrosive and flammable items are disposed of in a hazardous waste contained collected by the county recycling and hazardous waste disposal. The operating procedures also include disposal of hazardous items and toxic substances in accordance with Occupational Safety and Health Administration (OSHA). A review of the program's disposal log was completed to confirm the practice of disposing chemicals and waste. The facility administrator was interviewed, and stated disposal of hazardous chemicals is accomplished with the parameters of the state, local, and federal laws. Grease is thrown out in the grease trap located outside in the sally port area. All chemicals used can be disposed of in 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; therefore, 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 outlining the procedure for visitation and access to correspondence and telephone. Visitation for the youth is held on Saturday from 1:00 p.m. to 4:00 p.m. The visitation schedule is posted in the front lobby. Upon arrival each youth receives a youth handbook which details the visitation and communication process. Family members are required to sign in on a separate visitor sign-in roster. The program makes alternative visitation arrangements for parents/guardians if needed. All documentation reviewed was complete, in order and all requirements were met. Case management staff are responsible for maintaining the youth’s authorized telephone, mail, and visitation list. Youth have the capability of writing two letters a week and may earn extra letters and phone calls through the behavior management system. Incoming and outgoing mail is searched in the presence of the

youth. Five interviewed youth all reported they are able to communicate and correspond with family members through mail, telephone, and/or visitation.

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

The program has a policy and procedure in place for the use of Controlled Observation. Observations of the controlled observation room found the room met all requirements. The program reported having had no incidents involving the use of controlled observation for the scope of the annual compliance review.

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

The program has a policy and procedure in place for the use of Controlled Observation. Observations of the controlled observation room found the room met all requirements. The program reported having no incidents involving the use of controlled observation for the scope of the annual compliance review.

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

The program has a policy and procedure in place for the use of Controlled Observation. Observations of the controlled observation room found the room met all requirements. The program reported having had no incidents involving the use of controlled observation for the scope of the annual compliance review.

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

Five youth Safety Plans were reviewed with all five developed in the required timeframes. Parent/guardian interviews were conducted to help develop the Safety Plans. Staff interviews found several staff were unfamiliar with the term “Safety Plan”. The facility administrator was interviewed and stated the staff are not familiar with the term “Safety Plan”, as they are referred to as “My Stress Plan”, which is completed initially and every thirty days. The plans address youth warning signs, baseline behaviors, crisis recognition, coping strategies defined by the youth, intervention strategies preferred by the youth, and debriefing preferences. The plans incorporated recommendations when needed from previous clinical assessments and were inclusive of trauma responsive practices. Plans were updated every thirty days or following any significant behavioral or mental health event identified by the treatment team. Safety plans are maintained accessible to staff. Five youth interviews revealed three of five youth stating they

were involved in the development of their safety plans. The remaining youth stated they could not recall.