STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Cypress Creek

TrueCore Behavioral Sojutions, LLC
(Contract Provider)
2855 West Woodland Ridge Drive
Lecanto, Florida 324461

Review Date(s): May 12-15, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Renette Crosby, Office of Program Accountability, Lead Reviewer (Standard 1)
Tara Gilligan, Office of Program Accountability, (Interviews)
LeAnn Gruentzel, Office of Program Accountability (Standard 2)
Kristine Harshaw, Office of Program Accountability (Standard 5)
Amy Hutto, Office of Program Accountability (Standard 4)
Jennifer Schad, Office of Program Accountability (Standard 3)

Program Name: Cypress Creek Juvenile Offender Correctional Center/Cypress Creek Treatment Center
MQI Program Code: 1055
Provider Name: TrueCore Behavioral Solutions, LLC.
Contract Number: 10207
Location: Citrus County / Circuit 5
Number of Beds: 96
Review Date(s): May 12-15, 2020
Lead Reviewer Code: 186

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

Overall Rating Summary

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

Cypress Creek Juvenile Offender Correctional Center/Cypress Creek Treatment Center is a ninety-six-bed program, for fifteen to twenty-one-year-old males, located in Lecanto, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides mental health overlay services (MHOS). In addition, the program fosters each youth by providing Aggression Replacement Therapy (ART), Passport Program, Pathway for Self-Discovery and Change, the Teen Relationship Handbook, and Skillstreaming the Adolescent. Additional treatment services provided includes individual, group, and/or family counseling. Program administration is comprised of a facility administrator (FA), an assistant facility administrator (AFA) for operations, an assistant facility administrator (AFA) of security, a human resource manager, staff development coordinator, clinical director, assistant facility administrator (AFA) of support services, a school principal, health services administrator, and a physical plant manager. Case management services are provided by a director of case management, six case managers, an intake specialist, and two transitional service managers. Mental health staff at the program includes a contracted psychiatrist, a director of clinical services, assistant director of clinical services, five therapists, and two recreational therapists. Medical services are offered daily and are provided by a medical doctor who serves as the program's designated health authority (DHA), a health service administrator, three registered nurses, a contracted dentist and optometrist. Educational services are provided by the program. The layout of the program includes one main building and a portable. The main building has areas for administration, education, living units, kitchen, medical, treatment offices, and maintenance. The outside portable is used for vocational education. The program has sixty-nine operating security cameras providing coverage of the facility. At the time of the annual compliance review, the program had fourteen vacant positions including twelve youth care workers, one therapist, and one registered nurse. The program had one empty dorm during the annual review. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of specific elements were unable to be completed or were completed utilizing video recordings, conference calls, and on-site observations. Off-site supplemental reviews were conducted as desk audits throughout the remainder of this fiscal year.

Strengths and Innovative Approaches

- Youth are offered several certification options. Youth can earn Career and Professional Education (CAPE) certifications in Food Manager, ADOBE Photo Shop and Print shop, Pre-Apprenticeship Certificate Training Core, Occupational Health and Safety Administration (OSHA) 10, and OSHA 30. Youth can earn Certifications through the Home Builder's Institute program (HBI), hotel front desk clerk, line kitchen cook, first aid/automated external defibrillator (AED), cardiopulmonary resuscitation (CPR), landscaping, maintenance, pest control, building construction technology, painting, and leadership skills. Youth can also earn driving simulator certifications, and five hour drug and alcohol safety course, which is required for a driver’s license or learners permit. Youth can also earn a General Equivalency Diploma (GED) and take the American College Testing, Scholastic Achievement Test, and Postsecondary Education Readiness Test for math and English concordant scores for high school graduation and college placement. The program offers Employability Skills Training and offers the Test of Adult Basic Education test.

Standard 1: Management Accountability

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

The program has a written policy and procedures in place to address initial background screenings for staff, volunteers, interns, and mentors. Thirty-six staff personnel records were reviewed for initial background screening. All staff received a completed background screening prior to the staff's hire date. A criminal history report was reviewed each of the staff and none of the staff required an exemption prior to working with youth. All newly hired direct care staff records included the Berke Assessment, which the program utilizes as the pre-employment assessment tool, with a passing score. Documentation in all records included a review of the Central Communications Center Person Involvement History, Staff Verification System, and Florida Department of Law Enforcement as well as each staff added to the Clearinghouse employment roster. The program reported there were no volunteers or interns who required initial background screening during the annual compliance review period. The program completed and submitted the Annual Affidavit of Compliance with Level 2 Screening Standards December 16, 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.).	

The program has a written policy and procedures in place to address five-year background re-screenings. Eleven staff required a five-year re-screening during the annual compliance review period. Rescreening/resubmission documentation was submitted to the Department's Background Screening Unit (BSU)/Clearinghouse prior to the five-year anniversary and submitted at least ten business day prior to anniversary date or the retained prints expiration date.

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 to ensure youth reside in an abuse-free environment, free of intimidation, threats, or humiliation from staff. The policy further indicates Chapter thirty-nine of the Florida Statues mandates any person who knows, or has reasonable cause to suspect, a child is abused, neglected, or abandoned by a parent/guardian or other caregiver shall immediately report such knowledge to the Florida Abuse Hotline. A copy of the policy signed by all staff was available for review. Observations during the annual compliance review found evidence the Florida Abuse Hotline and number for the Central Communications Center (CCC) were posted in visible areas for youth and staff. The program's abuse reporting procedures is as follows: shift manager assist youth in making the call by dialing the appropriate phone number, the manager records date and time of call, operator name and number, and documents this information on an internal incident report. The youth are then allowed to communicate with the Florida Abuse Hotline operator. Staff are to maintain sight and contact with the youth but remain in area which allows for the youth to freely and confidentially report. Documentation was reviewed of the Trauma Responsive and Caring Environment (TRACE) self-assessment. Based on a review of the program's CCC report information received, the program had four incidents related to allegations of physical, psychological, or emotional abuse since the last annual compliance review. One of the four incidents remains open for investigation, two were found unsubstantiated, and the fourth incident resulted in staff termination. For all four incidents, the program's administration and human resources department provided documentation of evidence management took immediate action to address the incidents.

Seven staff were interviewed concerning the program's abuse reporting process. Staff reported supervisors are notified and youth are afforded opportunities to call the Florida Abuse Hotline, if needed. None of the staff reported they have heard a co-worker refusing a youth the opportunity to call the Florida Abuse Hotline, or ever heard a co-worker using profanity when speaking with

youth. Seven youth were interviewed. All youth reported feeling safe in the program, and they have never been stopped from making a call to the Florida Abuse Hotline. Each of the interviewed youth reported staff were respectful when speaking with them and other youth and did not use profanity.

1.04 Management Response to Allegations (Critical)	Satisfactory Compliance
Management shall be cognizant of youth and staff needs and provide direction to each on how to access the Florida Abuse Hotline. There is evidence management takes immediate action to address incidents of physical, psychological, and emotional abuse.	

The program had four incidents related to allegations of physical, psychological, or emotional abuse since the last annual compliance review. One of the four incidents remain open for investigation, two were found to be unsubstantiated, and fourth incident resulted in staff termination. For all four incidents, the program's administration and human resources department provided documentation indicating management took immediate action to address the incidents.

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 seventeen incidents reported to the Central Communications Center (CCC) during the annual compliance review period. This is a decrease from the previous annual compliance review period. A review of the internal grievances and incident documentation provided found no other incidents which were required to be reported to the CCC. A sample of five incidents were reviewed for reporting timeframes. All incidents were reported with the two-hour timeframe, as required. Three of five incidents were applicable and were documented within the program's logbook.

An interview with the facility administrator (FA) revealed new hire training and all staff meetings are utilized to ensure staff are knowledgeable on how to contact the Florida Abuse Hotline and CCC. and results of the calls are discussed as part of the training. In addition to the training, signage is posted throughout the facility and in the youth living quarters. CCC calls are documented in the master control logbook and are discussed in the daily management meeting.

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

The program has a written policy and procedures regarding the use of physical intervention techniques. The program's Protective Action Response (PAR) plan was approved by the Department. Upon the completion of a PAR report, there is a review of the PAR techniques,

including any applicable video, a discussion of how the situation could have been avoided, and a meeting which involves the youth. Based on review of PAR information provided and documented, the program had fifteen PAR incidents during the annual compliance review period; this is the same as the previous annual compliance review period. The program's PAR rate during the annual compliance review period was 1.06, which is below the statewide PAR rate of 2.28. Five PAR incidents were reviewed for completion requirements. A review of the incidents and documentation found each report was completed by the end of the staff member's workday and included statements from all staff involved. The incidents did not indicate any injuries to staff or youth and did not required a mechanical restraint supervision log. Each PAR incident was reviewed by a PAR certified instructor. The report information was reviewed by the facility administrator (FA) within seventy-two hours of the incident, as required. A copy of the PAR reports were placed in a centralized file within forty-eight hours of the FA's review and signature. An interview with the program's FA revealed incidents are reviewed daily in the management meeting.

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.	

Seven staff training records were reviewed to verify pre-service training requirements. A review of documentation indicated all of the staff were certified within 180 days of hire and completed more than the required 120 hours of pre-service training. All staff had certifications for cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR) training, professionalism and ethics, suicide prevention, emergency procedures, and Prison Rape Elimination Act (PREA). Three of the seven staff completed active shooter training. Six of seven staff completed training in child abuse reporting procedures. All required trainings were documented within the Department's Learning Management System (SkillPro). The instructors completing the training were qualified to do so, as each obtained trainer's instructor certifications. The program submitted, in writing, a list of pre-service training to the Office of Staff Development and Training, which included course names, descriptions, objectives, and training hours for any instructor-led training. The pre-service training plan was submitted on January 10, 2019 and approved by the Department on January 16, 2019.

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.*	

Seven staff training records were reviewed to verify the in-service training requirements. Four direct care staff (youth care workers) and three unit managers (supervisory staff) records were reviewed. Each of the staff surpassed the required twenty-four hours of in-service training. All seven staff had received training in cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED). Six of seven staff had received Protective Action Response (PAR) refresher training. The remaining staff remains out on workers compensation. Each of the staff received the full six hours of suicide prevention training. Suicide prevention training included two hours of web-based training in the Department's Learning Management

System (SkillPro) and four hours of instructor-led training. The three staff in supervisory positions all completed a minimum of eight hours of additional training in the areas of management, leadership, personal accountability, employee relations, communication, and/or fiscal training. All trainings were documented in SkillPro. The instructors completing the trainings were qualified to do so, as each obtained trainer's instructor certifications. The program submitted, in writing, a list of in-service training to the Office of Staff Development and Training, which included course names, descriptions, objectives, and training hours for any instructor-led training. The in-service training plan was submitted on January 10, 2019 and approved by the Department on January 16, 2019.

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

The program has a policy and procedures addressing the grievance process, which includes training requirements. A review of seven pre-service staff training records found each staff completed training on the program's grievance process. Grievance forms are available in each of the youth dorms. Phase One of the grievance procedures is allowing youth to verbalize and talk about their issues, Phase Two includes a Speak Out which is informal, and Phase Three is the grievance phase. The grievance process includes informal, formal, and appeal phases. Youth can appeal grievance phases to the facility administrator (FA). The program is required to respond to youth's grievances within twenty-four hours.

A review of grievances maintained by the program for the past twelve months included four grievances during the previous twelve months. The grievances were reviewed and three of the four were resolved at the formal phase, and within the required timeframe. The remaining grievance was appealed and resolved and within the required timeframe.

Seven youth were interviewed concerning the grievance process. Four of seven youth reported they have not completed a grievance; however, the youth were aware of the location of the forms and the process. The remaining three youth had completed grievances while at the program, knew the timeframes and process, as well as the location of the forms. All seven interviewed youth confirmed they can ask for assistance when completing a grievance. Seven staff were interviewed concerning the grievance process. The staff responded stating forms are located throughout the program and youth can request assistance in completing a grievance. The facility administrator (FA) was interviewed and advised, the informal process is resolved by using the Speak Out form. Youth place the grievance in the box, it is collected, reviewed during daily management meetings, logged, resolved with the youth, and if not resolved, the grievance is submitted to the FA.

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.	

A review of the provider's contractual agreement found the curriculum Impact of Crime (IOC) and Aggression Replacement Training (ART) are the program's primary delinquency interventions. A review of the training, education, and work experience of the staff providing the interventions include consideration of the level of education and the number of years of experience working with juvenile offenders. The program's activity and therapeutic group schedule determined the program is providing structured, planned programming activities at least sixty-percent of the youth's awake hours. Group sign-in sheets for both groups were reviewed and documented youth participation, ensuring groups were being delivered as indicated on the program's group schedule.

The facility administrator (FA) was interviewed and stated for mental health groups, staff must have a master's degree and for case management groups, staff must have years of experience or a bachelor's degree.

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 has a written policy and procedures to address life skills training. The program provides life and social skills training and intervention services addressing communication skills, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking skills training through group facilitation. Group sign-in sheets for life skills training were reviewed to determine groups were conducted, as required.

The clinical director advised the program provides services as dictated on a variety of curricula. Fidelity checks are conducted regularly to assure compliance with requirements. The checks address all aspects including group size, content of each session and appropriateness of each youth's participation in the group. Additionally, all clinical staff have been trained in each curriculum. Seven interviewed youth all reported they are participating in groups at the program. The youth stated they participate in groups such as Impact of Crime and Aggression Replacement Training. The seven youth were able to describe skills they have learned in the groups and all seven were able to provide a positive response.

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.	

According to the contract, the program provides Impact of Crime (IOC). Samples of group sign-in sheets were reviewed and confirmed groups were conducted, as required. Youth participate in community service projects which allow them to understand and accept responsibility for the

harm they have caused and challenges them to modify their irresponsible thinking. Seven youth case management records were reviewed for the delivery of restorative justice awareness. Each of the seven records had evidence of receiving services to help youth increase awareness and empathy for crime victims and survivors, as well as accountability for criminal actions and harm to others.

An interview with the facility administrator (FA) revealed IOC groups are held on Mondays and Wednesdays. The program currently has one IOC cohort running. Youth are exposed to activities through special activities and projects are completed for the team to take into the community due to the level of the program. Youth are exposed to victim's perspective through guest speakers and through the community advisory board victim advocate. Currently, the youth are involved in activities through groups and writing letters to their victims.

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 program's contractual agreement, the program is required to provide the curriculum Owning Up for gender-specific programming. The program's activity schedule is inclusive of 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, as required.

The facility administrator (FA) was interviewed and stated the program provides Owning Up curriculum and gender-specific topics during the monthly community meetings with the youth. The clinical director was interviewed and stated the program provides services as dictated on a variety of curricula. Fidelity checks are conducted regularly to assure compliance with requirements. The checks address all aspects including group size, content of each session, and appropriateness of each youth participation in the group.

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 addressing the internal and the Department's Juvenile Justice Information System (JJIS) alert systems, which determines how alerts are identified, documented, updated, and communicated to staff. The program maintains an internal alert system for all security, medical, and dietary alerts. Internal security alert information, as well as identification of youth on precautionary observation status, is captured in logbooks at the

beginning of each shift. A sample of log entries was reviewed to confirm the practice. Nurses update the medical alert system and youth boards daily. Five of the seven reviewed records were applicable for internal and JJIS alerts. All alerts were entered by the required staff member and were verified prior to entering into JJIS. All applicable alerts were documented in the program's logbook.

The facility administrator (FA) was interviewed and stated the program utilizes an internal alert form, as well as youth boards with alerts. Case management, medical, and mental health departments are responsible for JJIS entering and discontinuing the alerts. Management reviews alerts during the daily management meetings. Each of the seven interviewed staff reported they are notified of youth alerts through the alert board located in the breakroom and during shift briefings.

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 two separate records: an individual healthcare record and an individual management record. A review of individual management records found the records were all organized, as required, including a file tab which included the youth's name, Department identification number, date of birth, county of residence, and committing offense. All records were divided to include legal information, chronological information, correspondence, case management and treatment team activities, and a miscellaneous section. All records were labeled "confidential" and were secured behind two locks within the case managers' office. The program identifies doors 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 has formal processes in place to promote constructive input by youth. Can We Discuss forms are available in program areas and are used for youth to complete in the event the youth have any issues or concerns. Grievance forms are also made available within these locations. The program has a locked drop box provided for youth to deposit completed forms. The box is checked daily by the youth advocate. Samples of completed Can We Discuss forms and grievances were observed.

Seven youth were interviewed and all seven were able to describe the process for providing input. The facility administrator (FA) was interviewed concerning youth input and stated youth input is solicited during resident council meeting and documented through sign-in sheets and weekly agendas.

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

The program has a community advisory board which meets quarterly. Sign in sheets, agendas, and minutes from the past three meetings confirmed this practice. The advisory board includes members of the community such as law enforcement representatives, the judiciary, interested community partners, the business community, school board members, faith community, LBGTQI community, a victim, and a parent/guardian whose child was previously involved in the juvenile justice system. The program solicits advisory board participation from the following members: a representative from law enforcement, the judiciary, community partners, business community, faith community, victim advocate, and a parent/guardian whose child was previously involved in the juvenile justice system.

An interview with the facility administrator (FA) revealed the community advisory board gives input on the school schedule, creative suggestions to keep youth occupied, and gives us suggestions for community contacts.

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 to address program planning. Youth and parent/guardian surveys of released youth were reviewed to document the practice. The information from the surveys is taken into consideration and applied to program operations, as applicable. The management team meets daily, and all direct care staff participate in daily shift briefings. All-staff meetings are held monthly to provide feedback on program-related topics, training, and allow direct input from staff. The program displays the Comprehensive Accountability Report in the administration area of the facility. Survey results and results of the CAR are incorporated into the program planning process. The provider's corporate office sends the report annually, and information from the report is discussed with program staff during staff meetings.

Seven staff were interviewed. Four staff indicated staff meetings are held daily and five staff also stated daily and bi-monthly. All seven staff stated various topics are discussed during staff meetings and believe the information is valuable and informative. The facility administrator (FA) was interviewed and advised staff turnover varies, as well as staff morale. The program has an active staff morale committee. Administration meets with staff individually, complete surveys quarterly with corporate. Minimizing turnover is an ongoing process discussed in the management meeting.

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

The program has a policy and procedures in place to evaluate staff performance. The procedures indicate all staff receive an evaluation ninety-days after hire and annually thereafter. Seven personnel records were reviewed for performance evaluations which included positions for a therapist, youth care worker, unit manager, and transition case manager. All 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 program's contract revealed all key positions were currently maintained in the program.

An interview with the facility administrator (FA) advises staff are evaluated ninety days after hire and annually thereafter. Seven staff were interviewed, six staff advised they are evaluated annually, two staff stated evaluations are given at ninety days of hire then again annually to twice a year, and two staff were unsure as they have not been evaluated yet.

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

A review of the program's activity schedule includes activities such as visitation, education activities, recreation, and therapeutic activities. The program's activity schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities for youth. The program's logbook was reviewed and documented youth were moved for activities and recreation according to the schedule. The program has a written policy and procedures which include the provision of activities based on the development levels and needs of the youth. Youth are given choices for leisure and recreation activities. Youth are encouraged to explore interests, and youth were observed engaged in constructive use of leisure time. Activities offered by the program promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program takes precautionary measures to prevent over-exertion, heat stress, dehydration, frostbite, hypothermia, and exacerbation of existing illness or physical injury. Inside recreation is conducted on days when the weather is inclement (raining or too hot), youth with an existing illness or physical injury are placed on sports restriction until cleared by a medical professional. The program has two recreational therapists, who both have degrees in recreation. A review of seven youth records confirmed therapeutic/recreational activity provided is incorporated into the youth's individualized performance plan.

All seven interviewed staff reported youth receive one hour of recreation a day. Staff stated recreation included activities such as dodgeball, football, basketball, and various indoor activities. Each of the seven interviewed youth reported receiving one hour of recreation each day. The youth listed activities as cards, workout, draw, foursquare, basketball, and football. Each of the seven interviewed youth reported physical activities were provided for one hour. Two of seven reported they were not. Five of seven interviewed youth confirmed they were provided with varying degrees of mental and physical exertion throughout the day. Two stated they were not.

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.	

The program has written policies and procedures regarding notifying each youth's parent/guardian and the committing court of the youth's admission to the program. Seven youth case management records were reviewed. Each record contained documentation to support telephone notifications were made to the parent/guardian within twenty-four hours of youth's admission. All seven records contained written notification to the youth's parent/guardian within forty-eight hours, notifying them of their youth's arrival to the program. Each of the records contained supporting documentation indicating the program provided written notification to the committing court and the juvenile probation officer (JPO) the same day of the youth's admission.

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

The program has a policy and procedures to provide each youth an orientation to the program on the day of admission. The program utilizes an orientation checklist which included all services available, youth's responsibilities, daily schedule, contraband information, hygiene, dress code, emergency procedures, access to the Florida Abuse Hotline and the Central Communications Center (CCC), and availability of and access to medical and mental health services, as well as the information regarding the program's behavior management system. During orientation, the youth also receives information regarding room assignments, introductions to the staff, anticipated length of stay, and the physical design of the program. All seven reviewed case management records contained documentation confirming each youth was provided an orientation which began on the day of admission. Each youth was provided with a copy of the resident handbook, which provided further guidance on what youth can expect during their time in the program. Each record contained the orientation checklist completed upon the youth's admission and were signed by both the youth and staff. There were no new admissions during the annual compliance review. All seven interviewed youth stated the orientation began within twenty-four hours of their admission and included program rules, procedures, schedules, etc.

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.	

Seven youth case management records were reviewed. Three youth records were for youth who were eighteen years of age or older. Each applicable record contained a consent form

allowing the program to release information regarding the youth's physical or mental health screenings, assessments, or treatments to the youth's parent/guardian.

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

The program has written policy and procedures regarding classification factors, procedures, and reassessment for activities. A review of seven youth case management records found each record included an initial classification form which was completed on the date of each youth's admission to the program. The classification system included the youth's physical characteristics, age and maturity, identified whether the youth had any special needs, history of violence, gang affiliation, criminal behavior, sexual aggression, or vulnerability to victimization, as well as identifying suspected risks for suicide, escape, security, and medical issues. All seven youth case management records contained documentation indicating the youth were classified for the purposes of assignment to a living area, sleeping room, group, and case manager, which was confirmed by the interview of the facility administrator (FA).

The program has written policy and procedures requiring risk assessments to be completed prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools o instruments possibly used as potential weapons or means of escape. Participation in off-campus activity is not applicable. The youth are reviewed for reassessment during formal treatment team meetings. A continually updated internal alert system is used and is easily accessible to program staff, which keeps staff alerted of youth who are security or safety risks, including escape risks, suicide or other mental health risks, medical risks, sexual predator risks, and other assaultive or violent behavior risks.

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

Seven youth case management records were reviewed. Three of the seven youth case management records were for youth identified as gang members or having gang affiliation. Reviewed documentation indicated the program notified law enforcement, the youth's juvenile probation officer, and program case manager by email of each applicable youth's gang affiliation.

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.	

Seven youth case management records were reviewed. Three of the seven youth case management records were for youth identified as gang members or having gang affiliation. Each identified youth participated in intervention strategies through ARISE, treatment teams, and their performance plans included relevant goals relating to gang intervention strategies.

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.	

The program has a policy and procedures to assess each youth using the Residential Assessment for Youth (RAY) within thirty days of admission and reassessments every ninety days thereafter. Six of the seven case management records contained an initial RAY assessment, which was completed within thirty days of each youth's admission to the program. Each RAY assessment was appropriately maintained in the Department's Juvenile Justice Information System (JJIS). The remaining record was not applicable as the youth transferred to the program from another program who completed the initial RAY.

The program shall ensure a reassessment of each youth is conducted every ninety days after the initial RAY. The program shall ensure any other updates or reassessments are completed when deemed necessary by the intervention and treatment team to effectively manage the youth's case. The program shall maintain all reassessment documentation in the youth's official youth case record. Seven youth case management records were reviewed for RAY reassessments. Six of the seven youth case management records were applicable for the completion of at least one or more RAY reassessment. In each applicable record, a RAY reassessment was completed within ninety days or lass of the initial RAY assessment. All reassessments were documented in each youth's case management record and maintained in the Department's Juvenile Justice Information System (JJIS). One of the records was not applicable as the youth was transferred into the program from another program who completed the RAY reassessments.

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

The program has a policy and procedures to complete a Youth Needs Assessment Summary (YNAS) of each youth within thirty days of admission. Six of the seven youth case management records contained a Youth Needs Assessment Summary (YNAS) which was completed within

thirty days of the youth's admission to the program. Each YNAS was maintained in the youth's case management record and in the Department's Juvenile Justice Information System. One of the records was not applicable as the youth was transferred to the program from another program who completed the YNAS.

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

The program has a policy and procedures for the intervention and treatment team, including the youth, to meet and develop the youth's performance plan within thirty days of admission. Seven case management records were reviewed for the development of performance plans. All seven records documented the youth's performance plan was developed within thirty days of the youth's admission to the program. The performance plans were developed by the treatment team leader, youth, administration representative, living unit representative, treatment staff, education. Each of the interviewed youth reported the youth participated in the development of their performance plans and received a copy.

Each record contained performance plans which included specific delinquency interventions and individualized goals. The performance plan goals contained targeted dates for completion, youth's responsibility, and staff responsibility to enable the youth to complete the goals. Each of the goals identified on the performance plans were individualized and based upon the applicable youth's prioritized needs reflecting the risk and protective factors identified during the initial assessment process which included the top three criminogenic needs, court-ordered sanctions, transition activities targeted for the last sixty days of the youth's anticipated stay, and education.

There was documentation in all seven records to support the program sent the youth's performance plan to the youth's committing judge, juvenile probation officer, DCF case worker, and parent/guardian within ten working days of the plan completion. All seven reviewed plans revealed signatures by the youth, treatment team leader, and all parties with significant responsibility in goal completion. Six of the seven records contained a plan signed by the youth's parent/guardian which was returned to the program and attached to the original performance plans. One of the records was not applicable due to the youth being transferred into the program from another program who completed the initial performance plan. Seven applicable records contained documentation to support a copy of the plan was given to the youth.

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

The program has a policy and procedures regarding the revision of a youth's individualized performance plan based on the Residential Assessment for Youth (RAY) reassessment results, the youth's demonstrated progress or lack of progress toward completing a goal, or newly acquired or revealed information. Seven of the reviewed youth case management records contained performance plans revisions. Performance plans were revised and updated on an as needed basis. Three of the seven applicable performance plans were revised in response to the youth demonstrating progress towards a goal or if the RAY reassessment warranted.

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

The program has a policy and procedures regarding performance summaries. Performance summaries are required to be prepared 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. The summaries are required to be distributed within ten working days of signing. Seven youth case management records were reviewed. In each record, the performance summaries included the youth's status on each goal, youth's overall treatment progress, academic status, youth's behavior, level of motivation/readiness to change, interactions with staff and peers, overall behavior adjustment to the program, and significant positive and negative events.

Each of the youth case management records were reviewed for performance summary transmittals. Reviewed documentation revealed the youth was permitted to read and add comments to their performance summary prior to signing. The original summary was filed in the youth case management record. Each performance summary was signed and dated by the treatment team leader, the facility administrator (FA) or designee, and the youth. Documentation revealed the performance summaries were sent within ten working days of completion to the youth's assigned juvenile probation officer (JPO), parent/guardian, the committing court, Department of Children and Families (DCF) case worker, when applicable, and a copy was provided to the youth. All seven interviewed youth reported they received a copy of the performance summary.

One of the seven youth case management records was applicable for a discharge summary; therefor, two additional closed youth records were reviewed. All three applicable records contained documentation indicating the original summary was sent with the Pre-Release Notification (PRN) to the assigned JPO. Each release summary contained justification for the youth's release from the program and a signed copy was maintained in each youth's record.

There was documentation in all three records indicating the PRN was sent at least forty-five days prior to each youth's anticipated release date. Upon the court's approval of the PRN, all three records documented the program provided written notification to the youth's parent/guardian advising of the youth's anticipated release. The program completed a Residential Assessment for Youth (RAY) exit assessment.

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

The program has a policy and procedures to encourage and facilitate involvement of the youth's parent/guardian in the case management process. The program invites the youth's parent/guardian to participate in intervention and treatment team meetings for the purpose of developing the youth's performance plan. The program also mails treatment team letters to the parent/guardian, inviting them to attend the monthly treatment team meetings. If unable to attend in person, the program gives the parent/guardian the opportunity to participate by telephone or provide written input prior to the meeting. Parents/guardians are also invited to attend the youth's transition conference and exit staffing when placed in transition. A review of seven case management records found each contained documentation of the program's efforts to include each youth's parent/guardian in the case management process, including the initial assessment, development of the performance plan, progress reviews and formal treatment teams.

All seven interviewed youth reported their parents/guardians are involved in the case management. An interview with the facility administrator (FA) revealed the program encourages parental involvement in the case management processes.

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.	

Treatment team includes, at a minimum, the youth, representatives from the program's administration and residential living unit, and others responsible for providing or overseeing the provision of intervention and treatment services. All seven reviewed youth case management records documented treatment teams were composed of the treatment team leader, youth, administrative representative, treatment staff, educational staff, the youth's parent/guardian, juvenile probation officer, a representative from the youth's living unit, and the Department of Children and Families, when applicable.

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

The program has a policy and procedures for the intervention and treatment team to reference or incorporate the youth's treatment plan into the youth's performance plan. Seven youth case management records reviewed. Each youth's performance plan incorporated an academic plan and/or mental health and substance abuse treatment plan goals.

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

The program has a policy and procedures requiring the intervention and treatment team to meet bi-weekly to review each youth's performance, to include the Residential Assessment for Youth (RAY) reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions, and review youth's individualized treatment plan. Seven youth case management records were reviewed. Each record contained documentation indicating the intervention and treatment teams met bi-weekly, as required. The formal and informal treatment team reviews included the youth's name, date of review, meeting attendees, treatment team member's comments, a brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance goals, positive and negative behaviors, behaviors resulted in physical intervention, treatment progress, and one applicable RAY reassessment results. There was documentation in each record to support the youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were invited and encouraged through advance notification to participate in the formal treatment team reviews. Each youth was provided an opportunity during treatment team meetings to demonstrate skills learned in the program. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, an annual compliance review team member participated in treatment team meeting by telephone. Observations of the meeting determined all staff were present, and youth's performance was reviewed. A review of the Department's Juvenile Justice Information System (JJIS) determined the youth's anticipated release date was updated at least every ninety days.

All seven interviewed youth reported staff review youth performance, which included progress on performance plan goals, positive and negative behavior, and treatment progress, and the youth are given an opportunity during treatment team reviews to demonstrate skills learned in the program.

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

One of the seven youth case management records and two closed youth records were reviewed and were found to include a completed employment application, resume, Career Source Center information, appropriate documents essential to obtaining employment, and documentation indicating the youth's parent/guardian and juvenile probation officer were aware of the vocational plan for the youth. The program provides appropriate Career and Profession Education (CAPE) based on minimum length of stay of the program, which leads to pre-apprentice certifications and industry certifications. The program offers Type 2 and Type 3 vocational education is appropriate for the age of the youth and career education is appropriate for the educational abilities and goals of the youth in the program.

An interview with the facility administrator (FA) revealed the program offers career or vocational services through Home Builders Institute (HBI), employability, and hotel hospitality. An interview with the principal ensured career education services and assessment offered to the youth were food manager, ADOBE Photo Shop and Print Shop, Home Builders Institute Pre-apprenticeship Certificate Training, Occupational Safety and Health Administration 10 and Occupational Safety and Health Administration 30, front desk clerk, line kitchen cook, first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR), landscaping, maintenance, pest control, building construction technology, painting, and leadership skills.

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.	

TrueCore teachers provide education on a 250-day calendar, broken down into trimesters. There are six classes a day, each class period is fifty-five minutes. Youth receive credits for the education and training received while at the program. A review of the logbooks determined classes were held, as scheduled. All seven interviewed youth reported there is minimal interference in educational instruction.

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

One youth case management record and two closed records were reviewed for educational transition plans. Each record had an individual education transition plan developed based on the youth's post-release goals beginning at admission. All key personnel related to transition activities were involved in the development of the plan and the plans documented all parties' responsibility requirements, and the youth's post-release needs. All educational plans included copies of job applications, résumé, and other pertinent paperwork needed to enroll in an educational, employment, and vocational setting. Each record contained the completed vocational certificates demonstrating skills the youth learned in the program. Each record contained documentation of valid Florida identification cards, birth certificate, and social security cards. Each record had documentation the youth's case manager and guardian are aware of the plan, documents and post-release discharge plans.

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.*	

One youth case management record and two closed youth case management records were reviewed. Each youth had a transition conference held at least sixty days prior to the youth's targeted release date. Each of the youth case management records contained documentation indicating the youth, treatment team leader, facility administrator (FA) or designee, and other team members participated in the transition conference. The program emailed the juvenile probation officer (JPO) and the parent/guardian for information prior to the transition in case the parties are not able to participate. During the transition conference, the participants reviewed transition activities, identified specific target completion dates, and identified persons responsible for completion. Each youth's treatment team leader obtained signatures on the plan and a copy of the plan was sent to any member not present, requesting a signature and for the plan to be returned to the program. All records indicated the Community Re-Entry Team (CRT) meeting was conducted prior to the youth's release and both youth and case manager participated.

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.	

One youth case management record and two closed youth case management records were reviewed for exit portfolios. A copy of the exit portfolio was included in each record and documented as initiated during the transition conference. The exit portfolios included a copy of the transition plans. A calendar with all follow-up appointments, information in the community, vocational certificates, education records, school transcripts, resume, and completed job applications were also included in the exit portfolios. The staff printed driving directions with maps for the post-release scheduled appointments. Each record contained a copy of the youth's Social Security card, birth certificate, and state-issued identification card. All three records confirmed education staff forwarded a copy of the exit portfolio to the youth's juvenile probation officer and was documented in the youth's case management record.

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.	

One youth case management record and two closed youth case management records were reviewed for exit conference compliance. Each youth record contained documentation the exit conference was conducted at least fourteen days prior to the youth's release date and after the program notified the juvenile probation officer (JPO) of the release. A review of the Department's Juvenile Justice Information System (JJIS) confirmed the date of admission and release correlated with the dates documented in each record. The status of each youth's transition activities was reviewed. All reviewed records indicated the exit conference included the youth, the parent/guardian, JPO, treatment team leader, an education representative, and other pertinent staff. All exit conferences were separate from the transition and Community Re-Entry Team meetings.

Standard 3: Mental Health and Substance Abuse Services

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

The designated mental health clinician authority (DMHCA) is a licensed mental health counselor (LMHC). The DMHCA has a clear and active license in the State of Florida which expires March 31, 2021. The DMHCA is also a qualified supervisor mental health counselor and Certified Addictions Professional (CAP). At a minimum, the DMHCA was on-site weekly for a sufficient time to ensure appropriate coordination and implementation of mental health and substance abuse services were taking place. The DMHCA is responsible for coordinating and verifying implementation of necessary and appropriate mental health and substance abuse services in the program. The DMHCA provides clinical management of the program and supervision to the clinical staff to assure the overall safety of the youth. A copy of the DMHCA's license and position description was reviewed. An interview with the DMHCA indicated he provides clinical management of the program and supervision to the clinical staff and help assure the overall safety of the youth. Tasks include review of clinical assessments, treatment plans and other clinical documents. The DMHCA conducts fidelity checks of services including group, individual and family therapy, staffings and treatment team meetings. The DMHCA conducts drills three times monthly on suicide prevention, Baker Acts, and mental health crisis situations. The DMHCA is also responsible for scheduling of clinical staff and monitoring to assure services are provided in timely fashion.

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 designated mental health clinician authority (DHMCA) ensures the licensed clinical staff working under his supervision are performing services which they are qualified to provide based on education, training, and experience. The program has one other licensed clinical staff, the assistant director of clinical services, who is a licensed mental health counselor (LMHC). A review of the LMHC's license determined it is clear and active license in the state of Florida and expires March 31, 2021.

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

The designated mental health clinician authority (DMHCA) ensures the non-licensed clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The non-licensed mental health and substance abuse clinical staff are providing services in accordance with the current contract. The program has six non-licensed mental health clinical staff providing mental health and substance abuse services in accordance with the current contract. Three of the non-licensed staff have been employed at the program since the last annual compliance review and three were hired since. All six of the non-licensed mental health clinical staff work forty hours a week to include weekend coverage. There is coverage scheduled seven days a week. The DMHCA or the assistant director of clinical services, both licensed mental health counselors (LMHC), provide one hour a week of on-site face-to-face supervision with the six non-licensed clinical staff. A review of documentation for the past six months indicates supervision has been held each week, with no exceptions. The weekly supervision is documented on a form similar to the Department's form, Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA019). The form includes all the required information such as agenda, participants with signatures and credentials, facilitator with signature and credentials, caseload review, clinical services, documentation, and Standardized Program Evaluation Protocol (SPEP). Each of the six non-licensed mental health clinical staff hold the appropriate master's-level of education necessary and in accordance with the current contract. All six staff have master's-level degrees in social work, psychology, or counseling. The program is licensed in accordance with Chapter 397, Florida Statutes to provide substance abuse services. The license is current, expiring April 7, 2021. All six mental health clinical staff have received twenty hours training in Assessment of Suicide Risk (ASR). Seven youth mental health records were reviewed. Each mental health and substance abuse evaluation, initial treatment plan, and individual treatment plan completed by a non-licensed clinical staff was reviewed and signed by the DMHCA within ten calendar days. Each ASR completed by a non-licensed clinical staff was reviewed and signed by the DMHCA the next scheduled time he was on-site.

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

The program has a policy and procedures regarding mental health and substance abuse admission screenings. Seven youth mental health records were reviewed. All seven youth had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) administered on the day of admission. Each MAYSI-2 screening was completed by trained staff and completed in the Department's Juvenile Justice Information System (JJIS). All seven records had documentation indicating existing mental health and substance abuse information was reviewed from each commitment packet. All seven MAYSI-2 assessments indicated a further assessment was required. Four youth indicated "suicide ideation" on the MAYSI-2. The facility administrator (FA) was notified in each incident. It is the program's policy for all newly admitted youth to be

referred for a comprehensive mental health substance abuse evaluation and administered an Assessment of Suicide Risk (ASR) as part of the intake process. Documentation confirmed each youth had an ASR during intake. Additional screenings completed by the program at intake include the Substance Abuse Subtle Screening Inventory (SASSI-2), Adolescent Psychopathology Scale – Short Form (APS-SF), and About My Life. An interview with the facility administrator (FA) confirmed the screening procedure as outlined in the program's policy.

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

The program has a policy and procedures regarding mental health and substance abuse assessments and evaluations. Seven youth mental health records were reviewed, and each youth was referred for a new mental health evaluation on the day of admission. All seven youth had a mental health evaluation completed within thirty calendar days of admission. Six of the evaluations were completed by a non-licensed mental health clinical staff and signed by a licensed mental health professional on the same date, within the required ten calendar days after the evaluation was conducted. One evaluation was completed by a licensed mental health professional. The new evaluation included identifying information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression, and recommendations. Each evaluation also included a substance abuse assessment with patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, and risk factors of continued alcohol and other drug abuse.

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

The program has a policy and procedures regarding mental health and substance abuse treatment. Seven youth mental health records were reviewed. All seven youth were assigned to a treatment team upon arrival to the program. The multidisciplinary team was comprised of the youth, program administration, direct care staff, education, medical staff, and mental health staff. Treatment team documentation validated the teams were comprised of representatives from mental health and substance abuse, case manager, direct care staff, medical, education, and psychiatrist, if applicable. For the seven records reviewed, all youth received individual, group, and family counseling by a licensed qualified professional or a non-licensed substance abuse substance abuse clinical staff working under the direct supervision of a qualified professional as prescribed on the youth's individualized treatment plan. All seven of the youth receiving mental health treatment have an Authority for Treatment and Evaluation. All seven youth had signed Department Consent for Substance Abuse Treatment and Release of Substance Abuse Treatment Records forms. Each of the seven youth had documented diagnoses listed on their treatment plans and treatment plan reviews. Treatment progress notes

are documented on a form containing all the required information similar to the Department's Counseling/Therapy Progress Note form. Group therapy is limited to ten or fewer youth for mental health groups and fifteen or fewer youth for substance abuse groups as determined by a review of group sign-in sheets All staff providing group are qualified to provide services. All seven interviewed youth confirmed they are participating in group therapy. Each of the seven interviewed staff reported direct care staff do not conduct mental health or substance abuse groups. An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides services as dictated on a variety of curricula and fidelity checks are conducted regularly to assure compliance with requirements. The fidelity checks address all aspects including group size, content of each session and appropriateness of each youth participation in the group. Additionally, all clinical staff has been trained in each curriculum.

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.*	

The program has a policy and procedures regarding mental health and substance abuse treatment and discharge planning. Seven youth mental health records were reviewed, and all seven youth had an initial treatment plan developed on the day of admission. The initial mental health and substance abuse plans were documented on a form containing all the required information similar to Department Initial Mental Health/Substance Abuse Treatment Plan form (MHSA015). The initial treatment plan was signed by the mental health clinical staff completing the form. Six of the initial treatment plans were completed by a non-licensed clinical staff and signed by the licensed mental health professional within one date of completion. One initial treatment plan was completed by the designated mental health clinician authority (DMHCA), a licensed mental health counselor (LMHC). The initial treatment plan was signed by all treatment team members who participated in the development of the plan. Each initial treatment plan included the youth's psychiatric needs, including an initial evaluation by the program's psychiatrist.

All seven individualized treatment plans were developed for each youth within thirty days of admission. The individualized treatment plans were developed on a form containing all the requirements similar to Department Individualized Mental Health/Substance Abuse Treatment Plan form (MHSA016). Five individualized treatment plans were signed by the non-licensed mental health clinical staff completing the plan and signed by a licensed mental health professional within ten days of completion. One individualized treatment plan was signed by the non-licensed mental health clinical staff completing the plan and signed by a licensed mental health professional; however, a date was not noted for the licensed staff. One individualized treatment plan was completed by the DMHCA. Each plan was signed by all treatment team members who participated in the development of the plan. There was documentation indicating all seven plans were mailed to the parent/guardian for signature with two returned signed by the parent/guardian. Each treatment plan included psychiatric services for youth taking psychotropic

medications. Each youth had treatment plan reviews every thirty days following the development of the individualized treatment plan. The treatment plan review is documented on a form containing all the requirements similar to the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form (MHSA017). Progress notes determined youth received services as stipulated on the treatment plan with no exceptions.

Three closed youth mental health records were reviewed for discharge plans. All three records contained a discharge plan documented on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form (MHSA011). None of the youth were at suicide risk upon release. Each discharge plan included a recommendation of follow-up services for daily maintenance. Each discharge plan had documentation the plan was discussed with the youth, parent/guardian, and juvenile probation officer (JPO) at the transition and exit conferences. There was documentation a copy of the discharge plan was provided to the youth, parent/guardian, and JPO.

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 mental health overlay services (MHOS). Each youth receives mental health services which includes individual, group, and/or family counseling, seven days a week. Daily therapeutic activities are provided by mental health clinical staff. Psychiatric services are provided on-site biweekly. Youth with co-occurring substance abuse disorders receive substance abuse services. The program has a licensed mental health professional on-site at least five days a week. On weekends, licensed clinical staff are available, as needed. Each therapist has a caseload average of thirteen youth and caseloads do not exceed sixteen youth. Ongoing curriculum includes Aggression Replacement Training (ART), Passport Program, Pathway for Self-Discovery and Change, the Teen Relationship Handbook, and Skillstreaming the Adolescent. Clinical staff are on-site seven days a week. A review of seven youth mental health records confirmed, mental health services are being provided seven days per week.

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

The program has a contract with a psychiatrist to provide services on-site biweekly. Each youth admitted into the program receives an initial psychiatric evaluation within fourteen days of admission. All seven youth received an initial psychiatric evaluation within fourteen days of admission, regardless of their medication status. Four youth were applicable for psychotropic medications. Three youth were admitted into the program on psychotropic medications and one youth was subsequently prescribed psychotropic medications. The initial diagnostic psychiatric interview included medical history, mental health history, substance abuse history, mental status examination, documented diagnosis, treatment recommendations, prescribed medications,

explanation of the need for psychotropic medication, and frequency of medication monitoring. The evaluation was clearly identified as an “initial diagnostic psychiatric interview.” Page three of the Clinical Psychotropic Progress Note (CPPN) was completed for each youth. For the four youth on psychotropic medication, there was documentation indicating the youth had been seen for a medication review by the psychiatrist at a minimum, every thirty days.

The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. The psychiatrist meets with members of the treatment team biweekly, face-to-face, to discuss each youth scheduled for treatment team. The psychiatrist’s recommendations for the youth are incorporated into the youth’s individualized treatment plan. A review of documentation for the past six months confirmed the psychiatrist was on-site biweekly, for the contractually required hours, with no exceptions. The psychiatrist has a clear and active license to practice in the State of Florida expiring January 31, 2022. The psychiatrist has ultimate responsibility for the prescription and monitoring of psychotropic medications in the program. The psychiatrist actively participates in, manages and supervises psychotropic medication services in the program. The psychiatrist’s duties and responsibilities are not delegated. An interview with the psychiatrist confirmed his role in the coordination and implementation of psychiatric services in the program is to evaluate youth, coordinate care, and manage medication.

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 policy and procedures regarding suicide prevention services to include a written plan detailing suicide prevention procedures. The plan includes identification and assessment of youth at risk of suicide, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process which includes suicide attempts and a mortality review. The plan also includes staff training of six hours annually. The plan is reviewed annually and was last reviewed June 24, 2019 by the facility administrator (FA), designated mental health clinician authority (DMHCA), and psychiatrist.

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

The program has a policy and procedures to conduct an Assessment of Suicide Risk (ASR) for each youth admitted to the program. Seven youth mental health records were reviewed. All seven youth had an ASR completed at intake and, as a result, were placed on standard supervision. Three of those youth were admitted from a detention center, already on precaution

observation (PO) with an open alert in the Department's Juvenile Justice Information System (JJIS) already entered; the program removed the alert upon completion of the ASR. One of those youth had two additional incidents of PO. A third youth record was requested and reviewed. For the three incidents, the youth was determined to be a risk based on staff observations of youth. An ASR was completed for each incident, resulting in the youth being placed on constant supervision. For each incident, PO was authorized, mental health staff provided supportive services, and a follow-up ASR was completed prior to the removal of youth from PO. For each incident, a conference was held with the facility administrator (FA) prior to reducing the level of supervision. Discontinuation of close supervision was in accordance with the program's suicide prevention plan. There was documentation indicating the program notified the juvenile probation officer and parent/guardian of a youth's potential suicide risk, as indicated by the ASRs.

Each of the ASRs were completed by non-licensed clinical staff under the supervision of a licensed mental health professional or completed by a licensed mental health professional. Each of the ASRs were reviewed and signed by a licensed mental health professional on the same date or the next date. Each youth had an alert entered into JJIS. PO allowed youth to participate in select activities with other youths in designated safe housing areas of the facility. PO did not limit the youth's activity or restrict the youth to his sleeping room. There was documentation indicating all six non-licensed mental health clinical staff received twenty hours training to complete ASRs. The master control logbook documented each youth and each incident on PO. One incident had the youth on PO for thirteen days, including six days off-site in the hospital or mental health facility. Each ASR was completed in the required timeframe. Each ASR completed by a non-licensed mental health clinical staff was signed by a licensed mental health professional the next time the he or she was onsite. There was documentation on the ASR of the actual date and time the clinician conferred with the FA or designee. None of the youth reviewed were in secure observation.

The FA has an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide as part of the program's suicide prevention plan. The review includes circumstances surrounding the event, procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations for any changes, if needed. The program has a suicide response kit located in master control, in each of the two sub controls, one in the vocational classroom, and one in controlled observation. Due to the COVID-19 health risks, pictures of each of the suicide response kits were observed. Seven staff were interviewed. All seven staff indicated where one or more of the suicide response kits are kept at the program. For the interviewed staff regarding what to do when a youth expresses suicidal thoughts, all seven were able to describe what to do.

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 has a policy and procedures in place regarding suicide precaution observation (PO) logs. Seven youth mental health records were reviewed. All seven youth had an Assessment of Suicide Risk (ASR) completed at intake and, as a result, were placed on standard supervision. Three of those youth were admitted from a detention center, already on

PO with an open alert in the Department's juvenile justice information system (JJIS) already entered; the program removed the alert upon completion of the ASR. One of those youth had two additional incidents of being placed on PO. A third youth record was requested and reviewed. For the three incidents, the youth was determined to be a risk based on staff observations of youth. An ASR was completed for each incident, resulting in the youth being placed on constant supervision. The youth were placed on PO as soon as staff determined the youth were at risk for suicide. The PO logs for all three incidents were maintained for the duration the youth was on suicide precaution. The appropriate level of supervision and observations of the youth's behavior were documented in real time and did not exceed thirty-minute intervals. Any warning signs were documented on the PO log and mental health clinical staff were notified. Each PO log was reviewed and signed by a shift supervisor and by a mental health clinical staff. The PO logs documented safe housing requirements. The two were interviewed and confirmed while on PO, staff were with them at all times and they were not left alone.

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

Seven staff in-service training records were reviewed. All seven staff completed a minimum of six hours of annual suicide prevention and implementation of suicide precautions. The six hours of training included two hours of web-based training in the Department's Learning Management System (SkillPro), and four hours of instructor-led or webinar training. The last three completed quarters were reviewed for suicide drills. A drill was conducted each quarter and for each shift. One quarter had two suicide drills for each shift. In addition, for the last three quarters, the program has had three Baker Act drills and one mental health precaution drill. The program has had a mental health type drill each month on each shift for the past nine months. During the monthly all-staff meeting, staff review the previous mental health drill which is a standing agenda item. Each suicide drill included the use of cardiopulmonary resuscitation (CPR) and the suicide response kit. All reviewed staff participated in a quarterly drill, as required.

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

The program has a policy and procedures regarding mental health crisis intervention services which includes written crisis intervention procedures. The crisis intervention plan includes notification and alert system, means of referral, communication, supervision, documentation, and review. The plan is reviewed annually and was last reviewed June 24, 2019 by the facility administrator (FA), designated mental health clinician authority (DMHCA), and psychiatrist.

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

The program has a written crisis intervention plan which includes a process for implementation of a crisis assessment form. One of the seven reviewed mental health records was applicable for a crisis assessment; therefore, two additional records were reviewed. The program utilizes the Department's Crisis Assessment form (MHSA023). For each record, the youth had a crisis assessment on the same date the youth was determined to be in crisis. The crisis assessment included the reason for the assessment, mental status examination and interview, determination of danger to self or others, initial clinical impressions, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notification to parent/guardian. One crisis assessment was conducted by a non-licensed mental health clinical staff and reviewed by a licensed clinical staff. Two crisis assessments were completed by a licensed mental health professional. None of the crisis assessments required a mental health alert to be entered into the Department's Juvenile Justice Information System. One youth required close supervision which was appropriately documented on the close supervision log. The youth did not pose a safety and security risk. The youth did not require off-site care as a result of the crisis assessment.

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

The program has a policy and procedures regarding emergency mental health and substance abuse services which includes a written mental health and substance abuse plan. The emergency mental health and substance abuse services plan includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Baker Act, transport for emergency substance abuse assessment and treatment under Marchman Act, documentation, training, and review. The plan designates a local receiving facility for emergency transports. The plan is reviewed annually and was last reviewed June 24, 2019 by the facility administrator (FA), designated mental health clinician authority (DMHCA), and psychiatrist.

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 record applicable for Baker Act services during the scope of the annual compliance review. There were no youth who required Marchman Act services during the annual compliance review period. The youth who required Baker Act services was initially transported to a local hospital due to ingestion of a non-food item. The youth's attending medical doctor determined the youth was in need of emergency mental health care. The medical doctor completed the Baker Act paper work and the hospital arranged for youth's transportation to a mental health receiving facility. During the entire time the youth was in the hospital, program direct care staff were present with the youth. Due to the incident for which the youth was initially transported to the hospital, the youth was already on constant suicide precautions.

When the youth returned to the program, the youth was placed on constant supervision. The youth had an Assessment of Suicide Risk (ASR) completed by a non-licensed staff under the direct supervision of a licensed mental health professional. The youth was maintained on constant supervision until properly transitioned to a lower level of supervision. The youth's supervision level was not lowered until the mental health staff conferred with the facility administrator (FA).

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 designated health authority (DHA) is a licensed physician specializing in internal medicine. The DHA holds a clear and active license for independent and unsupervised practice in Florida which expires on January 31, 2021. The DHA was on-site weekly on Thursdays to provide medical care and clinic oversight. This schedule was verified through review of the DHA sign-in logs for the past six months. The DHA is responsible for communication with the program staff regarding youth medical needs and is on call twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The DHA has an agreement with an alternate physician to cover any scheduled absences. The alternate physician also specializes in internal medicine and has a clear and active license which expires on January 31, 2021.

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 designated health authority (DHA) and facility administrator (FA) documented an annual review of all written facility operating procedures (FOP) and treatment protocols as indicated by a dated signature on June 24, 2019. Approval of treatment protocols were developed and authorized by the DHA. Nursing staff members signed and dated a cover page indicating their review of the treatment protocols. All FOPs and protocols related to psychiatric services were reviewed and approved by the program's contracted psychiatrist.

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

Seven youth individual healthcare records were reviewed and six were applicable for an Authority for Evaluation and Treatment (AET) form. All six records contained a valid copy of the AET form. The forms were all legible, stamped "copy," and signed by the parent/guardian and a Department representative. Parental notifications were filed behind the AET in all six records. One youth entered the program at eighteen years of age, and two youth turned eighteen after arrival. All three records contained a completed release of information form. An interview with the nurse confirmed the AET form is a part of the admission packet for each youth. If there is not an AET form, the case manager is notified, who will then contact the youth's juvenile probation officer to obtain the AET form. The nurse also confirmed youth who are eighteen years of age or older do not require an AET and instead the facility completes a release of information which is signed by the youth.

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

Seven youth individual healthcare records were reviewed and six were applicable for parental notifications. The remaining youth was eighteen years of age upon arrival at the program. The notifications included the use of over-the-counter medications beyond those covered in the Authority for Evaluation and Treatment, changes in medication, and non-routine dental procedures. The progress notes reflected the signature of the staff member who witnessed the telephone call when consent was obtained by telephone. Four youth were receiving psychotropic medication. Documentation reflected notification was mailed along with the Clinical Psychotropic Progress Note (CPPN) and explanatory information when the youth was seen by the psychiatrist. Immunizations were verified for all seven youth within thirty days of the youth admission. Each youth's admission progress note confirmed the youth's immunization history was reviewed upon admission. An interview with the nurse confirmed the youth's immunization history review is completed through the Florida SHOTS website and/or by obtaining school records.

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

Seven youth individual healthcare records were reviewed, and each contained a Facility Entry Physical Health Screening (FEPHS) form. Each of the forms were completed by a registered nurse (RN) on the day of the youth's admission. Two youth had a change in physical custody and a new FEPHS form was completed for the youth upon their return.

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

Seven youth individual healthcare records were reviewed, and each record reflected the youth received a general care orientation upon admission to the program. The topics reviewed included: access to medical care, sick call, what constitutes an emergency, medication process, the right to refuse care, sexual assault, and the non-disciplinary role of the healthcare providers. The list of health care contacts was reviewed and confirmed to be accurate.

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

Seven youth individual healthcare records were reviewed, and the designated health authority (DHA) was notified of each youth's admission. The DHA was notified by fax at the time of each youth's admission which was documented on each intake admission progress note along with a copy of the fax confirmation.

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

Seven youth individual healthcare records were reviewed for completion of Health-Related History (HRH). In each youth's record, the HRH was completed on the day of the youth's admission, by a registered nurse (RN). In all seven records, the HRH was completed before the Comprehensive Physical Assessment (CPA) and the designated health authority (DHA) indicated their review of the HRH by checking the box on the CPA. An interview with the nurse confirmed the practice for completion of the HRH.

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

The program has a policy and procedures regarding Comprehensive Physical Assessments and Tuberculosis Screenings. Seven youth individual healthcare records were reviewed for completion of the Comprehensive Physical Assessment (CPA) form. The nurse indicated the designated health authority (DHA) completed a new CPA on all admissions within seven days of admission and on a yearly basis for all youth. The program uses a form which has all the same components as the Department's Comprehensive Physical Assessment (CPA) form. Each of the seven records had a CPA which was completed by the DHA within seven calendar days of their admission. All seven CPAs were fully completed and any part of the exam which was refused by the youth the DHA wrote "youth refused" and the youth signed the CPA. The Department's Problem List was updated as required.

Each of the seven youth records contained a verified tuberculin skin test (TST) which was documented on the youth's CPA and Infectious and Communicable Disease (ICD) forms. All seven youth were assessed prior to placement in the general population.

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

Seven youth individual healthcare records were reviewed and reflected each was screened for sexually transmitted infections (STI). The STI screening form was signed by the youth and nurse at the time of the youth's admission. The designated health authority (DHA) reviewed the form when the physical was completed, as documented by signature. None of the youth required further evaluation or testing.

All seven youth records documented the youth were each offered counseling, testing, and treatment, if needed, for Human Immunodeficiency Virus (HIV). Each youth refused testing. One nurse is 501 certified by the Health Department to provide HIV pre-test and post-test counseling services. The program has not completed any HIV testing since the last annual compliance review, as none of the youth requested testing. The program maintains an HIV testing log indicating refusal dates. All seven interviewed youth reported they could ask for HIV testing.

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

The program has policy and procedures in place regarding the sick call process. Seven youth records were reviewed, of which three were applicable for a sick call request. None of the youth presented with a similar sick call complaint three or more times within a two-week period, or with severe pain which staff were unfamiliar with. Each youth completed a Sick Call Request form and placed it in the sick call box. The nurse completed the sick call request form and filed the form in the youth healthcare record. Documentation included the youth's vital signs, treatment, education, and follow-up plans. Sick calls were documented on the sick call index and the sick call referral log. An interview with the nurse confirmed the sick call boxes are checked several times throughout the day and once each shift if there is not a nurse in the building. Youth are typically seen within twenty-four hours. The nurse further explained sick call is conducted in the clinic treatment room by a registered nurse daily between 2:30 p.m. and 5:45 p.m. and on the weekends between 9:00 a.m. and 11:00 a.m. The hours for sick call are posted in medical and on each dormitory.

All seven interviewed staff indicated the nurse or medical staff responds and conducts sick call. One of the seven interviewed youth reported youth are seen immediately after making a sick call request and the remaining six youth indicated they would be seen within one day. Due to the COVID-19 pandemic, this annual compliance review was completed off-site; therefore, sick call was unable to be observed.

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

The program has procedures for episodic and emergency care which include emergency medical and dental care are available twenty-four hours a day and program staff can call 9-1-1 for emergency medical services. A review of seven youth individual healthcare records reflected six youth received on-site first aid or episodic care. Each of the six instances reflected the day and time of episodic care, two received over-the-counter medications, all six documented the treatment provided, and the name and credentials of the person providing care and treatment. None of the youth required a referral for off-site care or placement on the alert list. Parental notification was completed for youth under the age of eighteen. The episodic care log reflected all instances of first aid and/or emergency care. There were no discrepancies indicated based on the youth records reviewed.

First aid kits are located in the kitchen, sub controls, controlled observation, vocational area and three are kept in master control for transports. The first aid kits are monitored weekly by the nurse and documented. The program has one automated external defibrillator (AED) which is located in master control, along with the procedures for the device. A nurse checks the AED monthly to ensure the battery and pads are operable. The batteries expire June 2024 and were last change February 2020. The AED pads expire June 2021 and were last changed July 2019. Documentation reflected emergency drills were held monthly on each shift and included the use

of AED and cardiopulmonary resuscitation (CPR). Emergency numbers, including Poison Information Control Center are posted in master control, medical, and the facility administrator's (FA) office.

A review of staff training records reflected staff were trained in the use of an epinephrine auto injector. Nurses and staff training records reflected they have current CPR, first aid, and AED training. Seven staff were interviewed and all seven stated they could call 9-1-1 in the event of a medical emergency.

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

Seven youth individual healthcare records were reviewed, of which two were applicable for off-site care; therefore, one additional record was reviewed. Two of the three records contained parental notification; the remaining youth was eighteen years old and did not require parental notification. In all three records, the Summary of Off-Site Care form was used and filed in the youth's record along with discharge and other related documents. The designated health authority reviewed and signed all off-site care findings, instructions, and information. None of the three youth required follow-up testing, referrals, or 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.	

The program has a policy and procedures regarding the evaluation and treatment of chronic conditions which requires frequent follow-ups at least every two months and monthly medication management. Seven youth individual healthcare records were reviewed, and four youth were applicable for taking psychotropic medications. Each of the four youth received an evaluation every month which was maintained in the youth's healthcare record. There were no lapses in care. Periodic evaluations were conducted prior to prescribing medication. The designated health authority confirmed periodic evaluation are completed every sixty days or more often as needed. He further indicated nurses maintain a chronic log and youth are scheduled by the nurses every sixty days or less.

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

Seven youth individual healthcare records were reviewed, and three youth were admitted to the program with prescribed medication. In all three records, the youth's medication status was documented on the admission progress note. Additionally, in each record, the designated health authority (DHA) was notified of the youth's admission and ordered the medication to continue, as prescribed. All the medications have a valid order and are provided pursuant to a current prescription. Review of youth records confirmed notifications to the DHA, psychiatrist, and parent/guardian were completed upon admission.

The program utilizes a pre-printed pharmacy Medication Administration Record (MAR) which contains the youth's name, date of birth, allergies, precautions, medical grade, medical alerts, start and stop dates, and a current picture of the youth. The MAR reflected staff initial each administered medication entry and there were no documented lapses or errors in medication administration. Nursing staff documents weekly side effect monitoring on the MAR. The Six Rights of Medication (right youth, right medication, right dose, right route, right time, and right documentation) were maintained by staff. One youth's MAR reflected refusals which were clearly documented on the MAR.

Observations reflected all medications are stored in a separate, secure area inaccessible to youth. All non-controlled medications are stored in a separate, secure area inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. The medical clinic has refrigerator with a lock for storage of medications requiring refrigeration. Syringes and sharps are secured. The medication cart was observed to be clean and organized, and stock items were separate from youth specific medications.

Medication pass was observed. Youth approach a window one at a time and the nurse confirms the youth's name, dorm, and medication. The nurse provides the youth with the medication and afterward staff swab the youth's mouth to ensure the medicine was swallowed. When medications need to be disposed of due to expiring or being discontinued if they are in a bubble pack they are sent back to the pharmacy, controlled narcotics are disposed of in a pharmacy approved liquid when the consultant pharmacist is on site monthly.

Seven staff were interviewed and all seven confirmed the nurse provides youth with medication, and one also stated all staff are trained to assist with medication pass. Seven youth were interviewed, and four stated the nurse provides their medication to them. The remaining three youth stated they do not take medication.

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

Medical equipment classified as sharps including syringes, needles, scissors, and suture removal kits were observed to be secured in the medical clinic and were inventoried using a routine perpetual inventory descending count as each sharp was used and disposed. All medications were identified and secured in the locked area designated for storage of medications (medication cart and cabinets and drawers in the clinic were locked). All controlled substances have a perpetual inventory and are stored separately from other medications. Controlled substances were also observed to be stored behind two locks with two separate key access. Documentation of the perpetual and weekly inventories of all sharps and stock over-the-counter (OTC) medications were reviewed and no discrepancies were noted. Documentation was reviewed of the shift-to-shit inventory count of all controlled substances documented on the youth's individualized controlled medication inventory record and no discrepancies were noted. Strict control and accountability of the running balance for each controlled substance is maintained. The number of pills remaining after each administered dosage was documented on the youth's individualized controlled medication inventory record. Three youth medications were inventoried, two of which were controlled medications. The count was accurate for each medication inventoried. Three OTC medications were inventoried and no discrepancies were

noted. Three sharps were also inventoried, and no discrepancies were noted. Program inventories for the past six months and the area designated to store sharps was reviewed. All medications are in a separate secure area inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Syringes and sharps are secured. The medication cart is clean and organized. All medical equipment classified as sharps are secured and inventoried weekly using a routine perpetual inventory descending count as each sharp is utilized and disposed.

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.	

Infection control procedures are in place at the program to include prevention, containment, treatment, and reporting requirements related to infectious diseases, as per Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The infection control procedures include the following: common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B, and C and Human Immunodeficiency Virus (HIV) infectious diseases caused by blood-borne pathogens, other outbreaks or epidemics caused by any other infectious agent, outbreaks of lice or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA) and other anti-biotic resistant micro-organisms, food-borne illnesses, bio-terrorist agents, and chemical exposures. Additionally, Hepatitis B immunization is available for all staff and staff have access to protective equipment. Documentation reflects standard universal precautions are followed by all staff. There were no instances in which it was necessary to notify the local health department, CDC, and/or the Central Communications Center of an infectious disease. The plan also includes provisions for needle stick post exposure evaluation. The program has a process to maintain all documents for youth or staff who have experienced a facility/occupational exposure.

The program's Exposure Control Plan is written in accordance with OSHA standards and is available to all staff. The facility administrator (FA) confirmed the plan is located in the staff breakroom, master control, and the policy and procedure book and it is reviewed yearly. The exposure control plan includes a risk assessment and methods of compliance. There were not three or more cases of any reportable infectious disease which needed to be reported to the local county health department or CDC. There were no instances involving quarantining or hospitalization of at least ten percent of the total youth population or staff.

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures regarding active supervision. The program's staff-to-youth ratio is one-to-eight during the day, one-to-twelve during sleeping hours, and one-to-five during transports or vocational activities. Observations of staff supervising youth were made on Wednesday of the annual compliance review by reviewing video of staff and youth interactions. Youth were observed, by video recording, participating in school, recreation, meals, and leaving on a transport. Staff were observed interacting positively with youth. The program has a full schedule of activities planned for weekdays, weekends, and holidays or other days when school is not in session. Youth were engaged in a full schedule of activities. Youth were always accounted for and accompanied. Youth are observed in their sleeping rooms at regular eight-minute intervals.

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

The program has a comprehensive behavior management system (BMS) which is clearly written and incorporated in the youth handbook. Rules governing conduct and positive and negative consequences for behaviors are posted in the living areas and in the youth handbook. The program's written BMS includes provisions to maintain order and security, positive and negative consequences, constructive disciplinary actions, opportunities for positive reinforcement, recognition of accomplishments and positive behaviors at a four-to-one ratio, promotes socially acceptable means for youth to meet their needs, process for explaining to youth the reason for any sanction imposed, youth have an opportunity to explain their behavior, opportunity for staff and youth to discuss impact of behavior on others, reasonable reparations for harm caused to others, discussion of alternate behaviors, promotion of positive dialogue and peaceful conflict resolution, separation of youth from population is minimized, and consistent implementation and treatment through oversight.

An interview with the facility administrator (FA) confirmed the program uses an incentive-based BMS. The FA further stated rewards are monitored through treatment teams and daily review of behavior reports. Five of seven interviewed staff indicated rewards and consequences are delivered in a four-to-one ratio. All seven staff explained the program uses a rewards-based system which include food, activities, and other tangible items. Two staff members described the program's level system for youth and how they advance to higher levels. Each of the seven interviewed youth were able to describe the difference between the levels. All seven youth were

also able to describe receiving consequences and consequences received such as a behavior report, canteen restriction, placement on security alert, and placement in controlled observation. Seven of seven youth indicated staff are consistent with rewards. All seven youth were able to list rewards used in the program to include special meals, snacks, additional television time, games, extra canteen, and movies.

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

The program's policy and procedures regarding the behavior management system (BMS) includes protocol where staff are provided feedback regarding their implementation of the BMS. A review was completed of position descriptions which specify required qualifications of staff whose job functions include implementation of the program's BMS. The program's BMS includes a process for staff to explain to the youth the reason for any sanction imposed, the youth then has an opportunity to explain their behavior, and staff and youth discuss alternative acceptable behaviors. The program utilizes controlled observation but does not use room restriction. A sample of controlled observation reports were reviewed and verified controlled observation was utilized based on major infractions to ensure both youth and staff safety. The BMS does not include increased length of stay, denial of basic rights or services, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement, wherein a youth is isolated in a locked room as discipline for misbehavior. Staff training regarding the BMS was reviewed. Fourteen staff training records were reviewed, and all staff completed BMS training.

Seven staff were interviewed regarding how supervisors provide feedback to staff regarding the implementation of the BMS. Six staff indicated feedback is provided during daily briefings. One staff indicated they are coached by their supervisor on how to use the BMS. Supervisors confirmed on site they monitor the staff use of the BMS and provide feedback to staff.
Six youth reported youth are never allowed to punish other youth. One youth responded yes in reference to the resident counsel students, and their roll in positive peer culture. Seven youth indicated staff are consistent in the use of rewards. Additionally, six youth rated the BMS as very good and one youth rated it as fair. An interview with the facility administrator revealed consequences are monitored through treatment team meetings.

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 eighty-six cameras with seventeen not currently operational. Video recordings are stored for thirty days. A sample of ten-minute checks were observed by video recording; all observed checks were completed on time and the staff members were observed stopping at each door and looking in the window. A review of ten-minute checks reflected the checks were conducted and documented in real time. Checks were reviewed for evening shifts on Alpha, Charlie, Delta, Echo, and Omega dorms. Bravo dorm was closed due to low youth numbers. The video review confirmed checks were completed every eight minutes. Additionally, a supervisor completed three of the checks on each dorm every shift. Seven staff were interviewed and each reported room checks are conducted every eight minutes when a youth is placed in their room for sleeping or non-punishment reasons.

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

The program has a policy and procedures regarding youth census, counts, and tracking. A review of logbooks reflected counts are conducted at the beginning of each shift, after each outdoor activity, during emergency situations, and during drills. Counts in the logbooks also reflected when youth are temporarily away from the program, such as for medical attention. Seven staff were interviewed regarding what happens when there is a discrepancy in a youth count. Staff reported counts are conducted at least three times on each shift. Staff further reported if the count is not accurate, a recount is conducted. If the recount is not accurate the third time, the youth are placed in their rooms and a supervisor conducts another recount.

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

Program logbooks were bound with numbered pages. All logbook entries were made in ink with no erasures or white-out areas. There were no entries which were obliterated or removed. All entries included the date and time of the event, the name of the staff and youth involved, a brief description of the event, and the signature of the staff making the entry. A shift briefing is conducted prior to the start of each shift to summarize events, incidents, and activities documented in the logbook. The program has detailed shift reports listing events for emergency situations, incidents, special instructions for supervision and monitoring of youth, population counts, perimeter security checks, transports, removal of any youth from the mainstream population, and admission and releases were documented in the logbook and the shift report. Staff acknowledgement of shift report is also noted in the logbook. Internal incidents reported to the Florida Abuse Hotline and/or the Central Communications Center (CCC) were documented.

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 on key control which includes key assignment and usage including restrictions on usage, inventory and tracking of keys, secure storage of keys not in use, procedures to address missing or lost keys, and reporting and replacement of damaged keys. The key inventory and storage area were reviewed. Keys are stored in a locked box within master control. Master control maintains daily inventory of the keys. Keys for medical, youth and staff records, and youth property are restricted. Administration and department heads have permanent issue keys. The program had no instances of lost or missing keys in the past six months. Master control receives staff keys at the beginning of their shift and staff are assigned program keys. In order for staff to receive their personal keys, staff must return the program keys to master control. A random check of three staff, including one administrator, revealed all had only had their assigned program keys and the keys on each selected key ring matched the key log inventory. Seven staff were interviewed regarding the key control process. Six staff reported keys are by managed by master control. Six staff reported there is a daily tracking of keys. Two indicated program keys are assigned to staff, one was aware of the key inventory, one reported they are to notify master control when keys are missing, and one stated maintenance replaces broken keys.

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

The program has a policy and procedures regarding contraband. The policy and procedures address any staff found in possession of contraband in a program will be subject to disciplinary action up to and including dismissal. Policy reflects law enforcement shall be contacted if any found item would be considered illegal, or if there is evidence of any type of unlawful activity. The program has a system in place to prevent contraband entering the program to include defining items and materials considered contraband. Youth are informed of this and the consequences if found with contraband in the student handbook. Logbooks reflected regular and random contraband searches of the physical plant, program grounds, and youth.

The facility administrator (FA) stated all contraband is given to the shift supervisor, then to the chief of security, and if necessary, the Central Communications Center is contacted. The program did not have incidents of contraband recovered in the past six months.

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

Youth searches are to occur before and after groups, before and after transports, during admission, and before and after visitation. Youth searches were observed prior to a transport, and prior to movement inside and group utilizing video recording. In each circumstance, the youth was treated with dignity and respect to minimize the youth's stress and embarrassment. The search was conducted by the appropriate number of staff and of the same gender as the youth. The search conducted was thorough and staff appeared to provide verbal instructions to the youth.

Seven youth were interviewed regarding when searches occur. Six of seven youth reported searches are conducted prior to movement, two stated when returning from off campus, three stated after outdoor activities, two stated when items are missing, and three stated after visitation. Seven staff were interviewed, and each explained searches are conducted anytime there is movement.

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

Invoices for each vehicle were reviewed which confirmed all three vans received an annual safety inspection and any deficiencies were corrected. All three vans used to transport youth were equipped with the appropriate number of seatbelts, a seat belt cutter, a window punch, a safety screen separating the front seats from the back, and a fire extinguisher. There are three first aid kits stored in master control which are placed in the van when used for transport. All vehicles in the parking lot of the program were secured while vacant.

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

The program has a policy and procedures regarding transportation of the youth. Preparation for a transport was observed by video recording. Two staff were assigned to transport one youth. The van was equipped with a safety screen separating the front seats from the back. Youth and staff wore seatbelts and the youth was not attached to any part of the vehicle. The vans used for transport have rear doors which cannot be opened from the inside. All staff operating program vehicles have a current driver's license, which is verified by human resources monthly. Per policy, staff are not to leave the youth unsupervised in the vehicle. Youth are not permitted to drive program or staff vehicles.

Seven staff were interviewed, and each reported staff are not allowed to use personal vehicles to transport youth. Three staff reported radios and cell phones are provided for staff on transport. Four stated radios are provided to staff during transports.

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 addressing weekly safety and security audits. The policy addresses who is responsible for conducting the weekly security audits and safety inspections, development, and implementation of corrective actions warranted as a result of safety and security deficiencies found during any internal or external inspection. The policy also addresses an internal system to verify deficiencies are corrected and existing systems are improved, or new systems are instituted to maintain compliance. A review reflected safety and security audits were completed weekly.

An interview with the facility administrator (FA) reflected there is a clear process regarding the identification, tracking, deficiencies to be addressed by the program through the safety inspection sheet, work orders, and items are discussed during the daily management meeting.

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

The program has procedures regarding the issuance, inventory, and control of equipment and tools. Tools are securely stored when not in use. Tools were observed to be marked for easy identification. The program maintains a monthly inventory of tools. Additionally, all tools are inventoried prior to being issued for work and following work activities. Machetes, bowie knives, or other long blade knives are prohibited. Staff follow procedures for missing, lost, or dysfunctional tools to include disposal and replacement. The inventory used to document issuance and return of tools was reviewed. Training documentation was reviewed for both staff and youth and confirmed they received training on the intended and safe use of tools.

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

The program has procedures for the supervision of youth handling tools. The program's procedures address issuing tools to youth and staff, including a risk assessment to determine youth's risk to self and others. The procedures address tool distribution and collection, and search criteria during work projects. The program maintains a ratio of one staff to five youth during activities involving tools. Risk assessments are completed on youth participating in tool projects or activities. Policy states youth are to be after work projects.

Seven staff were interviewed regarding which tools youth can use. Two staff stated youth are allowed to handle other tools when in Home Builders Institute (HBI). Six stated youth use mops and brooms. One staff reported the youth are allowed to use class B tools. Seven youth were interviewed regarding the tools they can use. Six youth stated they handle mops and brooms, two stated a scrub brush, two stated a hammer and saw for HBI, and one stated they can use a knife if working in the kitchen. Youth records reflect risk assessments are being conducted prior to tool usage.

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

The program has a policy and procedures regarding outside contractors. Sign-in sheets and instruction sheets for outside contractors were reviewed. Guidelines for repairmen and external worker tools include tools checked upon arrival and departure, tool restrictions while in the program, youth are restricted from the work area, and missing tool follow-up. Project invoices submitted to the program by the vendor were reviewed. Documentation reflected the date the project was worked on matched the sign-in sheets of the outside contractors. Documentation further confirmed the program inventoried the tools and equipment when the vendor arrived and departed the facility.

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 conducts practice drills and is prepared for immediate implementation or mobilization of the plans whenever an emergency or disaster situation necessitates. The assistance facility administrator (AFA) indicated fire drills are conducted monthly on each shift, and COOP drills are conducted once a month. This practice was confirmed through a review of drill documentation. Documentation of the drills contained the type of drill, date and time, participants, brief scenario, and findings/recommendations. Unannounced fire drills were conducted months under varied conditions and across all shifts. Fire evacuation routes and egress plans were posted throughout the program. The AFA confirmed fire drills are conducted monthly on each shift.

Seven youth were interviewed, and each reported they were instructed on what to do in case of a fire. Regarding how often fire drills occur, five youth indicated a frequency of every two weeks to once a month. Seven staff were interviewed regarding the drills they participated in within the last year. Seven staff indicated fire, one stated major disturbance, one reported hostage situation drill, four stated escape, and one reported a bomb threat drill.

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 Continuity of Operations Plan (COOP) is readily available to all staff in the breakroom. The COOP is reviewed and updated annually. The last date of review was on April 1, 2020, and documentation reflected the COOP was signed by the Department's regional director (RD) on April 23, 2020. The plan addresses alternative housing plans approved by the Department's RD. The COOP addresses fire and fire prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection.

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

The program has a policy and procedures on the storage and inventory of flammable, poisonous, and toxic items and materials. Flammable, poisonous, and toxic items are secured at all times. They are all stored in secured areas inaccessible to youth. Inventories were

maintained for all flammable, poisonous, and toxic items. The inventory was reviewed and matched the actual items within the program. There were no items missing or additional items not on the inventory. Safety Data Sheets are maintained on-site for all materials and stored with the materials, medical, and master control.

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

The program has a policy and procedures which address youth shall not handle flammable, poisonous, toxic items, and materials. The program maintains strict control of flammable, poisonous, and toxic items and materials. Youth do not use, handle, or clean-up dangerous or hazardous chemicals. Youth do not clean, handle, or dispose of any person's bio-hazardous material, bodily fluids, or human waste. There is restricted access to areas where items are used or stored. Seven youth were interviewed regarding the handling of supervision for flammable, poisonous, and toxic items and materials. All seven youth reported they do not handle chemicals.

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

The program has a policy and procedures on the disposal of flammable, toxic, caustic, and poisonous items. Disposal procedures are in accordance with the Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030. The program maintains a disposal log which indicated when and by what means the material was disposed. Receipts of disposals are also maintained in the log. The program disposes of materials at the Citrus County Landfill. Hazardous liquid waste is disposed of in accordance with the Safety Data Sheet (SDS). Liquid waste from work details is disposed of in the plumbing drains. Kitchen liquid waste, except grease, is disposed of in the kitchen. The program did not have any chemical spills in the past six months, but the policy and procedures reflect how chemical spills are cleaned-up. Upon becoming aware of a chemical spill, staff shall notify master control of the location. The shift supervisor or master control shall direct the shut-down of all air handlers and ventilation systems and close all windows and doors at the direction of the on-scene supervisor. Assistance from outside the program will be contacted, as necessary, consistent with emergency procedures.

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

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

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

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

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

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

The program does not participate in water 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.

At the time of the annual compliance review, in-person visitation has been suspended due to COVID-19 precautions. Prior to the shutdown, the program provided opportunities for youth to have in-person visitation. The program maintains a visitation log from prior to the suspension. The log included a list of approved visitors for each youth and a log which visitors completed. Youth are given the opportunity to communicate with family members by mail and telephone.

Seven youth were interviewed, and each reported they have the opportunity to communicate with family members by mail, telephone, or at visitation prior to the suspension of visitation. Youth are still able to communicate by phone or mail during the COVID-19 pandemic.

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 utilized controlled observation 109 times in the past six months. The rooms used for controlled observation meet all the requirements. Ten controlled observation reports were reviewed. In all ten reports, staff documented an inspection of the room and a search of the youth before the youth was placed in the room.

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

Ten controlled observation reports were reviewed. In all samples, the supervisory or higher-level staff authorized placement. In all instances, the youth were displaying active aggression, violent behavior, physically out-of-control, and staff advised the youth the reason of placement in controlled observation and expected behavior for removal. In all ten samples, a healthcare professional or staff of the same gender as the youth completed the health status checklist. In eight of the ten samples, the youth was in controlled observation over two hours. In these eight samples the assistant facility administrator or designee granted an extension every two hours.

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.	

Ten controlled observation reports were reviewed. In all ten samples, the staff making the placement completed the first page of the controlled observation report and submitted it to a supervisor. Staff documented safety checks at least every ten minutes and observations of the youth's behavior. Staff documented all safety checks and observations on the controlled observation safety checks form. The facility administrator (FA) or supervisor who has delegated authority gave written approval before the youth was released from controlled observation in all ten samples. The controlled observation report, health status checklist, and controlled observation safety checks were maintained in an administrative file. The assistant facility administrator (AFA) or designee reviewed and approved all ten controlled observation reports within fourteen days of the youth's release from controlled observation.

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.	

The program maintains a safety plan for each youth which is located in a binder within the staff break room. Seven youth safety plans were reviewed. All seven plans were completed within fourteen days of the youths' admission. The plans were documented to be jointly prepared by the youth and parent/guardian, and clinical staff. The plan for each youth included warning signs, youth's baseline behaviors, crisis recognition, coping strategies, intervention strategies,

and a debriefing process. All seven interviewed staff were aware of where the safety plans are located. Each of the seven interviewed youth reported they were involved in the development of their safety plans.