STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Dade Youth Academy
TrueCore Behavioral Solutions, LLC
(Contract Provider)
18500 South West 424th Avenue
Florida City, Florida 33034

Review Date(s): February 26 - March 1, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Gary Mogan, Office of Program Accountability, Lead Reviewer (Standard 1)
Nicos Antonakos, Office of Program Accountability, Technical Assistance Specialist (SPEP and Standard 2)
Virginia Jackson, Palm Beach Detention Center, Juvenile Justice Detention Officer Supervisor (Standard 2)
Peter Keelan, Office of Education, Department of Juvenile Justice Education Coordinator (Standard 2)
Marie Lockwood, Office of Program Accountability, Regional Monitor (Standard 4)
Shakela Minns, Office of Program Accountability, Regional Monitor (Standard 5)
Patrick Morse, Office of Program Accountability, Regional Supervisor (Standard 3)
Marissa Stress, Office of Program Accountability, Regional Monitor (Youth and Staff Interviews)

Program Name: Dade Youth Academy
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: Miami-Dade County / Circuit 11
Review Date(s): February 26 - March 1, 2019

MQI Program Code: 1418
Contract Number: 10080
Number of Beds: 24
Lead Reviewer Code: 149

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- **1** # Case Managers
- **3** # Clinical Staff
- **1** # Food Service Personnel
- **3** # Healthcare Staff
- **0** # Maintenance Personnel
- **3** # Program Supervisors
- **5** # Staff
- **5** # Youth
- **3** # Other (listed by title): **Regional compliance manager, regional clinical director, interns**

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	* Initial Background Screening	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	* Provision of an Abuse-Free Environment	Satisfactory
1.04	* Management Response to Allegations	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	Failed
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	Limited
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

* 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 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	Limited
3.14	* Mental Health Crisis Intervention Services	Satisfactory
3.15	* Crisis Assessments	Satisfactory
3.16	* Emergency Mental Health and Substance Abuse Services	Satisfactory
3.17	* Baker and Marchman Acts	Non-Applicable

* 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 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Room Restriction/Controlled Observation	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

* 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 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision	Limited
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	Failed
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	Limited
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handlins and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Recreation and Leisure Activities	Limited
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Non-Applicable
5.25	Controlled Observation	Non-Applicable
5.26	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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

Program Overview

Dade Youth Academy (DYA) is a twenty-four-bed program, for thirteen-eighteen-year-old males, located in Florida City, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides the following services: Thinking for a Change (T4C), Impact of Crime (IOC), Mental Health and Substance Abuse Overlay (MHOS), Teen Relationships, Young Men's Work, Anger Management, Thinking Feeling Behaving, Skill Streaming, and Living in Balance. In addition, the program fosters each youth by providing Daniel Memorial Independent Living assessments. Additional treatment services provided includes individual, group, recreational, and family therapy, coupled with transitional services. Program administration is comprised of a facility administrator (FA), an assistant facility administrator (AFA), a human resource director, a health services administrator, a director of clinical services, a director of case management, a physical plant manager, and a staff development specialist. Case management services are provided by a case management director, one case manager, and the transition specialist. Mental health staff at the program include a director of clinical services, one licensed therapist, and a master's-level non-licensed therapist working under the direct supervision of the clinical director, a recreation therapist, along with a records clerk. The program subcontracts services with a licensed psychologist and psychiatrist, along with a certified behavior analyst. Medical services are offered 8:00 a.m. through 10:00 p.m. seven days a week and are provided by a registered nurse (RN) who acts as the health services administrator. In addition, there is a second registered nurse along with a medical records clerk. The program contracts with a licensed medical doctor (MD) to serve as the Designated Health Authority (DHA). The DHA is on-site once a week for four hours. The program also subcontracts with First Choice, which provides all pharmaceuticals services, while also contracting with a local optometrist and dentist. Educational services are provided by the Miami-Dade County Public Schools (MDCPS). At the time of the annual compliance review, the program had eight youth care worker (YCW) II positions vacant along with two YCW I, one transition therapist, and one recreation therapist. The program practice is for all staff to be shared with both DYA and Dade Juvenile Residential Facility. The layout of the program includes an administration building, where the master control staff monitor the main security entrance. The administration building has offices for the management team. There are three dormitories for youth housing called Alpha, Bravo, and Charlee. The Alpha dormitory is strictly assigned to DYA youth. During a tour of the program, it was noted three of the ten sinks were draining on the floor, gang-related graffiti was observed in the shower, four of the nine toilets were out of order, and two of the four urinals were broken. There is an education building, a dining hall, a multi-purpose building used for indoor recreation and other youth activities, a supply/utility building, along with a maintenance building, which is outside of the secure perimeter fence. Laundry areas are located on the backside of each dormitory. Included in the multi-purpose building are offices for the medical clinic, case manager offices, and for the clinical staff. Both programs share thirty-two security cameras positioned in various locations through-out the facility. The Alpha dorm had two security cameras. At the time of the annual compliance review, all cameras were reported to be operational. The program has an approved Continuity of Operations Plan (COOP) in place. All tool and materials are maintained in a lock shed located outside the secure area of the facility. The staff work on three eight-hour shifts referred to as A-shift, B-shift, and C-shift. Staff are assigned to supervise youth based upon a contractual staffing ratio of one staff for every six youth. Youth progress is measured through the treatment services based upon a five-level Behavior Management System (BMS). The program is located in a remote environmentally sensitive area approaching the Florida Keys. Consequently, they are required to monitor and treat their waste water through a treatment

facility located on the grounds outside of the secure area. They have contracted this service with a class C water treatment company to monitor the discharge into the marsh area surrounding the complex. At the time of the annual compliance review, the Facility Administrator (FA) had been in the position less than ninety-days. Consequently, his knowledge of policy and practices of the program was still being sharpened. The FA was hired in November of 2018 and is still in the training phase while learning the program's practices, policies, and procedures of operation and becoming familiar with community agencies and partnerships.

Standard 1: Management Accountability

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

The program has a written policy and procedures for initial background screening. The program had thirty-four newly hired staff and four new volunteers since the last annual compliance review who required an initial background screening. A review of thirty-three staff records supported background screenings were completed, by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each individual's date of hire and/or contact with youth or access to confidential information. One staff was hired on December 3, 2018 and a background screening was not completed until February 4, 2019. One staff's background screening is pending; however, the staff is completing pre-service training with no youth contact. There were no staff requiring an exemption prior to the staff's date of hire. Each newly hired staff's criminal history and the Department's Central Communications Center (CCC) Person Involvement Report were reviewed. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to BSU on December 5, 2018, meeting the annual requirement. Reviewed documentation supported the teachers who are employed by the Miami-Dade County Public Schools received an annual background screening on December 24, 2018. A review of four volunteer background screenings found they were each completed prior to contact with youth. Each direct care staff hired after July 1, 2018 is required to complete a pre-employment assessment and receive a passing score. The program had twenty-four direct staff hired after July 1, 2018 who required a pre-employment assessment. Reviewed documentation found a pre-employment assessment was completed by each newly hired direct care staff and a copy of the passing score was maintained in each staff's personnel record. One staff did not receive a passing score but is still completing in-service training and will have another opportunity to take and pass the assessment prior to becoming certified.

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 addressing the rescreening process for staff every five years based upon their original date of hire. Rescreening documentation must be submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten days prior to the staff's five-year anniversary date. The program maintains a staff roster which is reviewed routinely by the program's human resources liaison to determine when a five-year

rescreening is required. The program had one five-year rescreen required since the last annual compliance review and documentation supported it was completed as required.

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

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

- *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse.*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety.*

The program has a policy and procedures which addresses a code of conduct. Seven applicable staff personnel records were reviewed, and each contained the signed acknowledgement, receipt, and review of the program's code of conduct. Observation of the physical plant during the annual compliance review found the telephone numbers for the Department's Central Communications Center (CCC) and the Florida Abuse Hotline posted throughout the program. The Facility Administrator (FA)reported youth have unimpeded access to the Florida Abuse Hotline and the CCC for youth who are eighteen years of age. If a youth requests to call the Florida Abuse Hotline, the youth care worker radios for a supervisor, and the youth is then taken to a telephone where they may make the call in private. There were seven applicable incidents during the annual review period which involved complaints against staff, of which five were reviewed. Each reviewed internal incident report and reports made to the Department's Central Communications Center (CCC) reflected all five incidents were reported to the CCC and the Florida Abuse Hotline as required. One of these incidents was substantiated and the staff was terminated. Two incidents are pending conclusion of an investigation, and two incidents were unsubstantiated. The FA stated once an allegation against staff is made, the staff is immediately removed from youth contact and an internal investigation is conducted. Action may include verbal warnings, written disciplinary action, suspension, and/or termination. Five interviewed youth reported feeling safe in the program and were not deprived of basic needs at any time. All five youth reported staff are respectful when speaking to them. Six interviewed staff reported never hearing a co-worker use profanity towards a youth or telling a youth they could not call the Florida Abuse Hotline.

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 maintains a written policy and procedures which addresses management's response to allegations. The program had seven incidents concerning allegations against staff for incidents of physical, psychological, and emotional abuse during this annual compliance review period, of which five were reviewed. Documentation for each incident supported management immediately initiated an internal investigation and removed each staff from youth contact. One incident was substantiated for use of excessive force, and the staff involved was terminated. Two incidents are pending an investigation and one of the two staff received additional training. Two incidents were unsubstantiated, and both staff were returned to duty; however, reviewed documentation found one of the staff returned to duty was not certified and should not have been counted in ratio or working independently on a specific shift. Two incidents were unsubstantiated, and both staff were returned to duty; however, reviewed documentation found one of the staff returned to duty was not certified and should not have been counted in ratio or working independently on a specific shift. An interview with the Facility Administrator (FA) explained youth and staff are knowledgeable in contacting the Florida Abuse Hotline and the Department's Central Communications Center (CCC) as the numbers are posted in the dormitories, school cafeteria, everywhere youth and staff are present. Upon entering the program, the Florida Abuse Hotline is part of the youth orientation along with new staff orientation training and annual in-service training. The FA further reported there have been no staff disciplined due to allegations of abuse towards a youth since the last annual compliance review.

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

The program has a written policy and procedures regarding reports to the Department's Central Communications Center (CCC). The program had eleven incidents reported to the CCC during the last six months, of which five were reviewed. Documentation validated each incident was reported to the CCC within the mandatory two-hour timeframe and in accordance with CCC reporting procedures. The program maintains a master binder for maintaining reports to the CCC. A review of shift reports for the past six months supported all reports were documented. A review of internal incidents for the past six months determined there were no incidents which should have been reported to the CCC but were not. All five interviewed youth indicated they never have been stopped from reporting abuse since they have been in the program.

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 maintains a written policy and procedures related to Protective Action Response (PAR). The program has a PAR plan approved by the Department's Office of Staff Development and Training on December 20, 2018. There were eighteen PAR incidents documented in the program's hardbound notebook for the past six months. A review of the five incident reports found each was completed by staff trained to perform physical intervention techniques, completed by all staff involved on the same day as the incident to include the nature of the intervention, date, and time. Mechanical restraints were not used in any of the reviewed PAR incidents. All PAR reports were reviewed by a PAR certified instructor or supervisory staff and determined the techniques used were approved by the Department. Only one of the five PAR reports indicated the need for a PAR medical review, as the youth sustained an abrasion on his lower lip. A post-PAR interview was conducted on each PAR report reviewed by the Facility administrator (FA) or designee within the required thirty-minute timeframe from the incident. Each PAR report was reviewed and signed by the FA the same day as the incident and placed in a central file. None of the reviewed reports required a report to the Central Communications Center (CCC), and there was no documentation to support any involved youth made a report to the Florida Abuse Hotline. Logbooks were reviewed, and documentation did not reveal any additional PAR incidents occurred. The program's PAR rate during the annual compliance review period was 2.99, which is above the statewide Residential PAR rate of 1.47. An interview with the FA regarding the process for monitoring PAR incidents and use of force is to review a completed report and subsequently discuss during the morning management meetings.

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

The program has a written policy and procedures addressing pre-service training. The program maintains a pre-service training plan and calendar for all new staff which was submitted to the Department's Office of Staff Development and Training on January 10, 2019 and approved on January 16, 2019. Three weeks of pre-service training, including one week of on-the-job training with certified staff is conducted through web-based and instructor-led courses. Seven staff training records were reviewed for pre-service training. Six reviewed records found each staff completed the certification process within 180 days of hire. One staff was hired on June 11, 2018 and has not completed and submitted his on-the-job training packet. Reviewed documentation supported all seven staff completed all required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. Six of seven reviewed training records supported each staff completed the required suicide prevention training prior to contact with youth. One staff was missing the four hours of instructor-led suicide prevention training. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro). The training coordinator confirmed staff

performing in all positions receive the same pre-service training, apart from the nursing staff. There are no additional training requirements outlined in the program's contract.

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

The program maintains a written in-service training plan which was submitted to the Department's Office of Staff Development and Training on January 10, 2019 and approved on January 16, 2019. Seven applicable staff training records, including three supervisor's training records, were reviewed for in-service training. Each reviewed staff training record documented the staff exceeded the twenty-four hours of in-service training requirements. Each staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff also completed training in professionalism and ethics, including standards of conduct. Six staff completed training in suicide prevention inclusive of two hours web-based and four hours instructor-led. One staff was missing the four hours of instructor-led suicide prevention training. Three supervisor training records were reviewed for completion of eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, communications skills, and fiscal. Reviewed documentation supported each supervisor exceeded this requirement. All trainings were delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro). The program's contract was reviewed and confirmed there were no additional training requirements.

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

The program has a written policy and procedures to provide a structure and written process which allows youth to grieve actions of the program, staff, conditions of the program, or circumstances within the program which are related to a violation or denial of their basic rights. The program has a three-phase protocol which consist of an informal, formal, and appeal phases. As part of the informal process, has implemented a speak-out process as an alternative. Youth are informed of the grievance process during admission into the program. Grievance forms are available to youth in the dorm area and are located on the wall in a file holder next to the locked grievance box which is accessible to all youth. Youth who have difficulty completing the form may receive assistance by staff on the instructions, preparing, and submittal of a grievance. The program had a total of twenty-seven grievances for the past six months which are maintained in a designated grievance binder. A random review of five grievance forms verified the youth were provided the proper form and each grievance was resolved at the formal phase. A review of staff training records verified grievance training is provided during the pre-service training period. An interview with the Facility Administrator (FA)

indicated the FA was able to explain the program's grievance process to include the three phases. The Speak Out notebook submitted for review only contained forms from October of 2018 through January 2019. On the grievance form the grievance classification for identification of a "formal" and/or "to be handled as an informal complaint" was not identified in any of the five grievance forms reviewed. Additional grievance forms were reviewed and none of the forms documented staff identifying as to how the grievance was to be addressed. The FA further responded in an interview by informing when a youth completes a written grievance form staff know the youth's concern is to be considered a formal grievance. Consequently, the check box is not marked. Six interviewed staff were able to describe the program's grievance process. Five youth were interviewed, and each knew how to file a grievance and stated they could ask for assistance in completing the form if necessary.

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

The program provides delinquency interventions through evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. A review of the program's contract outlined the evidence-based Thinking for a Change (T4C) as the delinquency intervention model used at the program. The program also utilizes the evidence-based T4C curriculum. Three current staff training records were reviewed. All three staff were trained to facilitate T4C and have bachelor's-level degrees. One staff has over twenty years of experience working with youth, one staff has nine years of experience, and one staff has a year experience. An interview with the Facility Administrator (FA) indicated the staff members work experience and/or education level determines which staff meet the requirements to deliver life skills training or conducting groups. The FA also indicated youth are matched to staff, counselors, case managers, and intervention groups during the pre-staffing meeting and the pre-classification meeting. The program's activity schedule determined youth did spend at least sixty percent of their awake hours in structured, planned programing and/or activities. A review of T4C sign-in sheets determined groups are being delivered as designed. Five youth records were reviewed which indicated four of five youth completed a T4C group. The youth who did not complete the T4C intervention will participate in the next cycle of T4C; however, the program could not provide a date as to when the next cohort of T4C will begin. All five youth assessments identified delinquency intervention as a priority need. All five youth performance plans also included delinquency intervention goals.

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

The program has a policy and procedures providing life skills training to the youth. The program identified Teen Relationships, Skillstreaming the Adolescent, Thinking, Feeling Behaving, and the Daniel Memorial Independent Living Assessment as life skills training and were provided to the youth during the annual compliance review period. The life skills groups specifically address communication, interpersonal relationships and interactions, non-violent conflict resolution,

anger management and critical thinking. Youth are assessed during the intake process and placed in groups which meet their criminogenic needs. A review of the activity schedule confirmed life skills groups are being provided. A review of Teen Relationships sign-in sheets verified youth are receiving life skills training. All staff facilitating groups have been trained in the curriculums. Interviewed administration staff stated youth can practice skills in group role-play activities and interactions with staff and youth at the program. Five interviewed youth confirmed they were able to demonstrate the skills doing role play activities during groups. A review of five youth records indicated all five youth were participating Teen Relationships group. A Teen Relationships group was observed during the annual compliance review week. The facilitator was prepared for group and was comfortable facilitating. All youth participated in the activity. An interview with the program's facility administrator validated youth are participating in the Daniel Memorial Independent Living Assessment for Like Skills groups.

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

The program has policies and procedures regarding providing restorative justice awareness to the youth. A review of the program's contract identified Impact of Crime (IOC) curriculum as the required service to provide restorative justice awareness to youth. IOC is designed to assist youth to accept responsibility for harm they have caused by their past criminal actions and teaches youth about the impact of crime on their victims, their families, and their communities. The IOC groups expose youth to victim's perspectives through victim speakers, in person or through digital versatile disc (DVD) videos and provides opportunities for youth to participate in reparation activities such as community service projects, writing letters to military personnel, and writing letters of apology to the victims. A review of training records verified three staff were trained to facilitate IOC groups. The interviewed administration staff stated some youth completed community service hours with Bridge to Hope Church to help feed the homeless to give back to the community. The program did not provide IOC groups to the youth since March 2018. Five youth records were reviewed, and none of five youth attended or completed IOC groups during the annual compliance review period. Two out of the five youth completed three and one-half hours of community service helping to feed the homeless at Bridge to Hope Church.

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

A review of the program's contract did outline specific services for gender-specific programming which identified Young Men's Work (YMW) as the gender specific curriculum provided to the youth. YMW addresses the needs of young men and is designed to provide services on the common characteristics of young men. The curriculum was reviewed and verified the material is appropriate to instruct on gender-specific issues. A review of the program's activity schedule and the sign-in sheets confirmed gender-specific programing is provided to the youth. The Facility Administrator indicated in an interview all youth will participate in the evidenced-based YMW groups, which addresses many aspects of the characteristics of the program's population. During the annual compliance review week, a YMW group was unable to be observed.

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 regarding entering alerts in the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. An interview with the program's facility administrator (FA) confirmed the JJIS alert reports and internal alerts are distributed and reviewed by shift supervisors and administration, daily. Upon review of the alert lists, the supervisors discuss the alerts with all working direct care staff, at each shift briefing. A current alert list is maintained in master control, in each dormitory, the medical clinic, and in the kitchen. A review of shift reports confirmed alerts are a standing agenda items. The medical, mental health and substance abuse staff, as well as the case managers, and administration enter and update any applicable or critical alerts in the JJIS alert system and the program's internal alert system. If a youth with an alert is admitted to the program after a shift's briefing, the appropriate entity updates the internal alert list and the JJIS alert system and immediately distributes the new list to the shift supervisors, administration, and the kitchen, at which time the information is verbally communicated to direct care staff. A review of five youth records found each was applicable to have an alert entered into the program's internal alert system and the JJIS alert database. Three of the five youth alerts were applicable to be downgraded and documentation confirmed each were downgraded by the appropriate party; however, there was no documentation in the program's logbooks or in the shift reports reflecting the change in alert status, but there was documentation to support they were removed from precautionary observation. Five staff interviews confirmed staff are notified of alerts during each shift's briefing. An informal interview with staff supervising youth while in school stated they do not have an alert list with them and cannot identify which youth have alerts unless they are on precautionary observation. Staff stated they could obtain the alert information if they request it from the shift supervisor, medical, mental health during the day. An interview with the FA reflected mental health, medical or the food services manager is responsible for closing alerts in JJIS. The FA further stated staff are informed of alerts during management team meetings.

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

The program maintains separate hardbound binders for case management, healthcare, and mental health and substance abuse records, all of which are maintained by the respective departments. Observations of the records found each marked "confidential" and secured in assigned offices when not in use. Reviewed records contained all of the most recent information

in chronological order. Within each reviewed record, information was separated into clearly labeled designated sections for legal, demographic, case management with treatment plan and interventions, and correspondence, along with a miscellaneous tab.

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

The program has established a youth advisory board which allows an avenue for youth to discuss issues, concerns, and suggestions for possible changes in practice. The youth dormitory representatives are chosen by the treatment team members, rewarding youth who have demonstrated positive behaviors and compliance with treatment goals. If a youth is interested in becoming a member of the advisory board, he completes an application and is subsequently interviewed during his assigned formal treatment team meeting. The youth advisory board meets monthly to discuss issues such as food service including special monthly meals, behavior incentives, specialized programming, holiday and community service activities, abuse protocols, healthcare, along with an open floor forum. Advisory board members are the liaisons between the youth and program administration. An interview with the Facility Administrator (FA) and reviewed sign-in sheets validated meetings are held monthly. Representatives of the program's management team inclusive of the Director of Case Management and the Recreation Therapist monitor the meetings and offer advice from the management perspective. The youth advisory board helps youth feel a part of the process with valued opinions and input. In addition to the youth advisory board, all youth participate in daily community meetings to discuss any presenting issues they may have during the course of their day. Youth are also encouraged to utilize Speak Out forms as an avenue to convey suggests or complaints. Five youth were interviewed and stated they have a process to provide input into what happens at the program.

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

The program maintains a written policy and procedures establishing a community advisory board. The community partnerships have been developed to connect the local community with the goals and objectives of the program's design. The partnerships have been established with the local school system, local religious groups, the Florida City Police Department, the City of Sweetwater Commission, victim advocacy services, the University of Miami Sociology Department, the Homestead Police Department, and Good Hope Equestrian Center. There was no documented judiciary or a parent/guardian of a youth who is a former client of the Department and the program did not provide recruitment efforts for these members. A telephone interview was conducted with a representative for Exchange for Change, a non-profit organization which teaches reading to at-risk youth. The representative stated she attended advisory board meetings from December 2017 through May 2018 but stopped attending due to lack of management follow-up or youth willing to participate in the program. The program maintains a hardbound notebook listing all the partnership agencies and businesses. In addition, there was supporting documentation to reflect notices are sent by e-mail and/or United States Postal Service to each community partner inviting them to attend the upcoming advisory board meeting. This practice was confirmed by the Facility Administrator in an interview. The supporting documentation reflected the meetings occurred during the months of February 2018, May 2018, June 2018, and December 2018 with a copy of the agenda, sign-in sheets, and

minutes from the previous community partnership meeting. There was no supporting documentation to indicate a meeting was held during the third quarter. The next community advisory board meeting is scheduled for March 20, 2019.

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 establish and utilize effective channels of communication among the program staff, corporate leaders, other agencies, stakeholders, and between youth and staff. The program conducts shift briefings, monthly staff meetings, weekly management team meetings, and quarterly community advisory board meetings to review and address pertinent information and follow up on program operations, health services, mental health services, case management, education, human resource, and support services. A review of the meeting minutes and agendas for each meeting verified they are held as required. An interview with the Facility Administrator (FA) indicated staff are kept informed through shift briefings and monthly staff meetings. Active recruiting is ongoing to address staff vacancies. In order to increase staff retention and employee morale, the program identifies an employee of the week, month and year, as well as cook-outs and employee outings. Youth and parent/guardian surveys are conducted during visitation and upon the youth's release from the program. Additional information the FA provided during the interview process indicated the outcome data used by the program are the parent/guardian exit forms, feedback during treatment team, feedback during individual and family sessions. Random review of surveys included feedback for case management, mental health, food, and medical services. In addition, the FA stated the information received from the youth and parent/guardian surveys are reviewed by the corporate office and are forwarded to the individual program. The information is then shared during manager's, and all staff meetings and incorporated into the program's planning process. Five staff were interviewed, and all reflected staff meetings are held monthly. The topics which are discussed in the meetings are program matter, youth issues, alerts, incidents, and policy changes. Five staff interviewed and four stated they are briefed on the Comprehensive Accountability Reports (CAR), annual compliance reports, and youth and parent/guardian survey reports. One staff stated they were not briefed on the reports and was unsure of the purpose for the reports. Five staff were interviewed on how they believe the communication is amongst the staff in the program. Two staff stated communication is very good, two responded good, while one staff stated communication is very poor. Each staff validated information is conveyed during shift briefings and all staff meetings.

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 addressing the evaluation of staff performance. Performance evaluation measures are completed annually for in-service staff and at the initial ninety-day probationary period for pre-service staff, addressing areas including basic job knowledge, reliability, attendance, education and training, initiative, adherence to policy, interpersonal relationships, judgement, competency, and goals achieved. The evaluation process also includes best practice elements adapted by the program. Evaluations are unique for the specific types of staff positions at the program. Staff who facilitate groups are evaluated for their skills at facilitating a delinquency intervention, and all staff are evaluated on the implementation of the program's behavior management system. Staff are rated using the rating

guidelines of commendable (3), acceptable (2), needs improvement (1), unacceptable (0), and not applicable (N/A). Staff are provided an overall numerical range of job performance scores at the conclusion of the evaluation form as a method to advise each staff of how they are performing. Once reviewed by staff, they are given the opportunity to provide their signature on the evaluation form along with any comments. The employee performance evaluation practice was confirmed in an interview with the Facility Administrator (FA). Five personnel records were reviewed inclusive of youth care workers, a supervisor, a case manager, and a therapist, and each included the job description for the applicable specific position, applicable performance evaluations, education records and degrees, and a copy of the acknowledgement for the program's code of conduct. Six staff were interviewed and one state they receive a performance evaluation annually, two stated they receive a performance evaluation on a monthly basis, while one response was every ninety-days. Two staff did not answer the question.

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 policy and procedures to notify a youth's parent/guardian by telephone as well as in writing regarding each youth's admission into the program. The program's policy also identifies procedures to provide written notification to the youth's committing court of each youth's admission. Five youth case management records were reviewed, and each contained documentation indicating the youth's parent/guardian was notified by telephone within twenty-four hours of the youth's admission into the program. Each reviewed record also included documentation of the youth's parent/guardian being notified in writing within forty-eight hours of the youth's admission into the program and written notification to the committing judge, assigned juvenile probation officer, and applicable post-residential services counselor within five working days of each youth's admission into the program.

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

The program has written policy and procedures in place to ensure each youth is oriented to the program on the day of their admission. An orientation checklist is used to explain and discuss the program's rules, schedules, and services available. Youth are also provided a copy of the youth handbook which includes information regarding services available, program goals, expectations and responsibilities and rules of the youth, emergency procedures, daily schedules, room assignment, search policy including which items are considered contraband, visitation, grievance procedures, the behavior management system (BMS), dress code, and hygiene practices, performance planning, anticipated length of stay, how to access medical and mental health services, key staff and their roles, access to Florida Abuse Hotline, and access to the Department's Central Communications Center (CCC) for youth eighteen years of age or older. Each youth signs an acknowledgement form to indicate their receipt of the youth handbook. Five youth case management records were reviewed, and each record contained documentation indicating each youth received an orientation on the day of their admission as well as a youth handbook. There were no admissions to observe during the annual compliance review week. Five youth were interviewed and all stated they received an orientation within twenty-four hours of admission and were able to explain the orientation process.

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

The program has a written policy and procedures to ensure written consent is obtained from youth eighteen years of age or older before providing or discussing to the youth's physical and mental health and/or substance abuse assessment and treatment with a parent/guardian or any other interested party. A review of three applicable case management records contained a written consent for youth over the age of eighteen years.

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

The program has a policy and procedures regarding a classification process to assign youth to a living and/or sleeping room on the day of admission. The program's policy also indicates procedures to reassess and/or reclassify youth to determine the youth's eligibility for off-campus activities and participation in work projects or other activities involving tools or instruments. The program utilizes a classification system to promote safety and security for which a youth's classification is determined by their individual and risk factors. Five youth case management records were reviewed, and each contained an admission classification form which identified physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, aggression, suicide risk, medical risk, escape risk, and security risk of each youth. A review of the Department's Juvenile Justice Information System (JJIS) confirmed alerts match the identified alerts found and utilized during each youth's classification. Further review indicated room assignment was based on the youth's classification and each reviewed youth received a risk reassessment prior to participation in off-campus activities or participating in work detail which required the use of tools. The program maintains a continually updated internal alert system documenting any medical, mental health, security risks, or special needs identified during the initial classification process or identified throughout the youth's stay at the program. An interview with the Facility Administrator (FA) indicated each youth participates in a classification meeting with their treatment team to address possible victimization factors, vulnerabilities and/or lack of vulnerabilities.

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

The program has a written policy and procedures to screen youth during the admission and classification process, to determine if youth is a gang member or gang affiliated. Three applicable case management records were reviewed for youth being documented as a gang member. In each applicable record, the program notified local law enforcement and the youth's home county law enforcement in writing of the youth's gang status. Each of the three reviewed records reflected the information was also shared with the youth's juvenile probation officer (JPO), the Miami-Dade County Public Schools, and documented in the Department's Juvenile Justice Information System (JJIS) as an alert.

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

The program has a written policy and procedures to ensure implementation of gang prevention and intervention strategies are provided when youth are identified as being a gang member or affiliated gang member. Youth are screened during the admission process to determine if they are associated with a gang or an active gang member. Part of the assessment includes a criminal street gang criteria assessment. Any youth displaying gang signs, paraphernalia, slogans, participating in any gang-related activity to include flashing gang signs, wearing gang colors, tagging, recruitment, and/or promoting a gang lifestyle will be identified and addressed by administrative staff and the treatment team. The program utilizes the Impact of Crime (IOC) intervention group as part of their gang prevention curriculum. Three applicable youth case management records were reviewed and identified goals were included in each performance plan relating to gang prevention/intervention. Identified youth are required to complete a security threat group questionnaire, which is strictly a gang-related inquiry form. Supporting documentation of sign-in sheets and youth essays validated identified gang youth were participating in the GANGS: 50+ Stories of Fractured Lives curriculum, which is a group meeting two times a month dating back to September 25, 2018.

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

The program has a written policy and procedures to ensure an assessment of each youth using the Residential Positive Achievement Change Tool (R-PACT) is completed within thirty days of admission and R-PACT reassessments are completed within ninety days after completing the initial R-PACT assessment. Five youth case management records were reviewed, and all records indicated each youth was assessed using the R-PACT within thirty days of admission

and were being maintained in the Department's Juvenile Justice Information System (JJIS). A review of five youth case management records found four were applicable for R-PACT reassessments. Each of the applicable youth records contained an R-PACT reassessment which were maintained in JJIS, completed within ninety days of their initial R-PACT assessment, and a copy maintained in each youth's case management record.

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

The program has a written policy and procedures to ensure a Youth Needs Assessment Summary (YNAS) is completed on each youth in the program within the first thirty days of admission to the program. Five youth case management records were reviewed, and each contained a YNAS completed within thirty days of the youth's admission and were documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has a written policy and procedures to ensure the intervention and treatment team members, including the youth, meet to develop a performance plan for each youth within thirty days of admission. Each performance plan goal shall specify target dates for completion, the youth's responsibilities to compete the goal, and the program's responsibilities to enable the youth to complete the goal. The plan shall be dated and signed by the youth, intervention and treatment team leader, the treatment team members, parent/guardian if possible, and any other parties with significant responsibilities toward completing the goals. Five youth case management records were reviewed for performance plan development. Each reviewed plan was developed within thirty days of the youth's admission, contained measurable goals developed by the treatment team and the youth, identified court-ordered sanctions, contained a transition goal to address barriers for a successful release, included the responsibilities of the youth and staff, addressed the top three criminogenic needs, and identified target dates for completion. In each reviewed performance plan, development of the plan involved the treatment team leader, youth, parent/guardian, administrative representative, living unit representative, treatment team staff, educational staff, Department of Children and Families (DCF) staff when applicable, and was signed by all parties. Each reviewed record contained the original performance plan and a copy was provided to the youth. Five youth were interviewed on the treatment process. Each interviewed youth knew the program's treatment process including the

development of their performance plan and knew the goals on their plan. However, only one youth responded they had received a copy of their performance plan. Five youth case management records were reviewed for performance plan transmittal. Each of the reviewed records contained an electronic transmittal indicating a copy of the performance plan was sent to the youth's parent/guardians, juvenile probation officer (JPO), and committing court.

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 written policy and procedures in place regarding revision of each youth's performance plan. The program's treatment team may revise a youth's performance plan at any time a new need is discovered based upon Residential Positive Achievement Change Tool (R-PACT) reassessment results, when the youth has demonstrated progress or lack of progress towards completing a goal, and/or when newly acquired information is revealed. Five case management records were reviewed, and all records contained documentation of a performance plan revision. Each revision reflected the R-PACT reassessment results, newly acquired and updated information, coupled with progress and/or lack of progress towards completion of the youth's performance plan goals.

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

The program has a policy and procedures regarding performance summaries and transmittals. A review of five open youth records verified the performance plan was updated every ninety days calendar days following the signing of the initial performance plan. A review of three closed records indicated the performance plan summaries were prepared prior to the youth's discharge from the program. Five reviewed performance summaries included the youth's status on performance goals, overall treatment progress, youth's academic status, youth's behavior, level of readiness to change, interaction with peers and staff, and significant positive or negative events. Three closed performance summaries included justification for release from the program. A review of five open records included evidence the youth was able to read and add comments prior to signing the performance summary. The youth received a copy and the original performance summary which was filed in the case management record. The performance summaries were signed by the treatment team leader, program director or designee and the youth. A copy of the performance summary was sent to the committing court, youth's juvenile probation officer, youth, and parent/guardian within ten working days. Three closed records verified the original summary, justification for release and the pre-release notification (PRN) were sent to the juvenile probation officer (JPO). The release summary was sent at least forty-five days prior to the planned release. Signed copies were retained in the youth's case management record. Of the three reviewed closed records a court objection to the

release of the youth from the program was not applicable. Once the program received the approved PRN, a written notification was sent to the parent/guardian of the planned release date. The program did not have sexually violent predator program (SVPP) youth. Three closed records reviewed did not require a victim notification letter to be mailed. A review of five youth interviews, three youth stated they received a copy of the performance summary, one responded they did not, while another responded not applicable.

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 regarding parent/guardian involvement in case management services. The program encourages and facilitates involvement of youth's parent/guardian in case management process which included assessment process, participation in the development of the youth's performance plan, progress reviews, formal treatment team meetings, and transition planning. If the parent/guardian is not able to attend, they may participate by telephone or give verbal/written input prior to the meeting. A review of the program's contract confirmed the performance expectations were being met. An observation of a treatment team meeting was conducted during the review and the parent/guardian participated by telephone. The program mails letters or informs parents/guardians by telephone during weekly calls about upcoming treatment teams and family day events. In an interview with the program director the parents are encouraged to participate in the case management process by writing letters, weekly phone calls, sending pictures and participate in monthly treatment team meetings. Five out of five youth interviewed stated the parents/guardians participated in case management services.

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

The program has a policy and procedures addressing members of the treatment team. A review of five youth records identified the following treatment team members participated in the formal treatment meeting; the treatment team leader, youth, administration representative, treatment staff, clinical director, director of case management, and transition services manager. The living unit representative and education staff provided written input, and the juvenile probation officer (JPO) and parent/guardian participated by telephone. The program's gang prevention specialist will participate as needed. Observation of a formal treatment team found all members provided feedback to the youth, both positive and negative. The youth were actively engaged in the treatment team. The youth were aware of their performance goals and able to discuss their progress on goals.

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 regarding the incorporation of other plans into the performance plan. Five youth records were reviewed, and all included an academic plan and

mental health plan incorporated in the performance plan. Out of the five youth records reviewed, none of the records were applicable for the Department of Children and Families (DCF) behavior support plans or youth identified with the Agency for Persons with a Disability.

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

The program has a policy and procedures regarding treatment team meetings. The treatment team members were invited and encouraged through advance notification to participate or provide written input to include the youth's juvenile probation officer (JPO), the youth's parent/guardian, and other pertinent parties. Five youth records were reviewed and all five had evidence the formal reviews were held at least every thirty days. The five formal treatment teams reviewed included the youth's name, date of review, all required meeting attendees which included the youth, case manager, mental health and substance abuse therapist, program administration representative, and director of case management. The parent/guardian and the youth's JPO participated by telephone and the education department and the living unit representative provided written input. The formal treatment team review included comments from treatment team members, brief synopsis of youth's progress at the program, progress on performance goals, positive and negative behaviors, any performance plan revisions if needed, any behaviors resulting in physical interventions, the treatment progress and Residential Positive Achievement Change Tool (R-PACT) reassessment results. Youth are also provided an opportunity to demonstrate skills acquired at the program through group role play activities and interaction with staff and peers at the program. The five reviewed youth records indicated the informal reviews were held bi-weekly each month. The informal performance review documentation included the youth's name, date of review, meeting attendees, and any comments from treatment team members. The review also included comments from treatment team members, brief synopsis of youth's progress at the program, progress on performance goals, positive and negative behaviors, any performance plan revisions if needed, any behaviors resulting in physical interventions, the treatment progress and R-PACT reassessment results. An observation of a formal treatment team was conducted during the annual compliance review week. All required staff were present including the education representative. The discussion included youth's progress on the performance plan, positive and negative behaviors, and youth's treatment progress. All members actively participated in the meeting. Four out of five interviewed youth stated they were provided the opportunity to demonstrate skills learned at the program during treatment team meetings and staff reviewed the youth's performance at the program. One of the five youth interviewed responded no to the question of being able to demonstrate skills learned at the program. In follow-up, the youth was unsure why he responded in the manner he did.

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

The program provides a type 2 educational programming. The programming includes the teaching of personal accountability skills and behaviors leading to appropriate work habits for employment as well as practical life skills. This programming also includes the teaching of communication, interpersonal and decision-making skills. Youth with employability as a goal identified in their individualized performance plan, were introduced to and completed a detailed employment résumé and sample job applications, which were archived within the youth's individual exit portfolio. Each youth record also appropriate documents which were essential for the youth to gain employment, obtain a Department of Highway and Motor Vehicle state identification card or license, Social Security card, and a birth certificate. Three closed youth records were reviewed and all contained the essential documents, as well as the youth's successful participation in the Serve-Safe Certification culinary arts program. According to the lead teacher, in addition to the culinary arts youth participate in assessments for Florida View Inventory, Florida Common Assessments, preparation for the general education development (GED) diploma, Career Research and Decision Making, Exploration of Career and Technical Programs and testing, the Armed Services Vocational Aptitude Battery (ASVAB), the Scholastic Aptitude Test (SAT) and the American College Testing (ACT) preparatory examinations. The student data is documented in the student education folder, progress monitoring plans, electronic education exit plan (EEEP), transition plan and the school district's information management system (DSIS). The information is then shared bi-weekly through progress monitoring plans, which are subsequently updated regularly for treatment team meetings. The specific educational services and interventions based upon the youth's assessed needs and post-release education plans are address in the progress monitoring plan and correspond directly to the Florida Common Assessment. The facility administrator (FA) stated youth are offered a career or vocational services training in the Safe Staff food handling certification program.

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

The program requires youth to participate in educational and career-related programs for 250 days of instruction distributed over twelve months for a minimum of twenty-five hours of instruction each week. A review of the program's daily academic schedule reflected the school's daily schedule begins at 7:20 a.m. and concludes at 2:00 p.m. A review of the program's master control logbooks confirmed classes were being conducted with very minimal interruption.

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

The program has a policy and established procedures addressing transition, release and discharge. Three closed management youth records were reviewed, and each confirmed the youth had an individual education transition plan which were based upon the youth's post-release goals. Each plan addressed services and interventions founded upon the youth's

assessed educational needs and post-release goals. The plan also incorporated specific monitoring responsibilities by explicitly identified individuals who are responsible for the reintegration and coordination for the provision of support services. As part of preparing the youth for transition from the program, the education program involves the youth expressing employment as a transition goal with appropriate coaching in choosing of a career choice, creating and writing of résumés, completion of employment applications, as well as conducting mock job interviews. Three closed youth records were reviewed and all three indicated the required transition activities, target dates, and individual responsibilities were identified. In addition, each transition plan was recognized and accepted with signature by the youth, the youth's parent/guardian, a representative of the program's education component, the youth's juvenile probation officer (JPO), the transitional representative, coupled with case management and other staff involved in the post-release and re-entry process.

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

A review of three closed youth records verified the transition conference was held at least sixty days prior to the targeted release date. The following individuals attended the transition conference; youth, treatment team leader, program director or designee, and other team members. The youth's juvenile probation officer (JPO), parent/guardian, education staff and any other pertinent members were encouraged to participate or provide written input. During the transition conference, the participants reviewed transition activities on the performance plan, revised the plan if needed, identified additional transition activities as needed, identified target completion dates, and identified persons responsible for completion of the goal. The treatment team leader obtained attendees dated signatures. A copy of the plan was sent with a request for return signature of anyone not in attendance. Each plan was sent to the JPO electronically with the email acknowledgement receipt printed and filed with the plan. Three closed records were reviewed, and all records included evidence a community re-entry team (CRT) meeting was conducted prior to the youth's release. The youth and case manager were invited and participated in the CRT meeting.

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

Three closed records were reviewed, and all indicated the exit portfolio was discussed and introduced at the transition conference. The following items were included in the exit portfolio, Department of Highway and Safety Motor Vehicle state issued identification card, copy of the transition plan, calendar with all dates/times/locations of follow-up appointments in the community. Also provided to the youth over fifteen years old, a social security card, birth certificate, any vocational certificates earned, all education records, school transcripts, résumé, and sample job applications. Education staff sent the exit portfolio information to the receiving school district. A review of documentation confirmed the exit portfolio was discussed at the exit conference, the exit portfolio was given to the youth upon release, and was forwarded to the assigned juvenile probation officer (JPO). A review of the program's contract confirmed the program is meeting all the requirements regarding the exit portfolio.

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.	

A review of three closed records confirmed the exit conference was conducted after the program notified the assigned juvenile probation officer (JPO) of the youth's release and at least fourteen days prior to release. Documentation in the case records included the date, signatures and a summary of pending transition goals. The date of admission and the date of release correlated with the entries in the Department's Juvenile Justice Information System (JJIS) system. The following individuals participated in the exit conference; treatment team leader, parent/guardian, and education representative.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor (LMHC) with a clear and active license in the State of Florida, with an expiration date of March 31, 2019, serving as the Designated Mental Health Clinician Authority (DMHCA) and the clinical director. The DMHCA is full-time, working Monday through Friday from 9:00 a.m. to 5:00 p.m. The DMHCA is on-call twenty-four hours a day, seven days a week and is responsible for the coordination and implementation of mental health, substance abuse, and specialized services at Dade Youth Academy and Dade Juvenile Residential Facility. The facility administrator is responsible for ensuring the mental health and substance abuse services are provided by individuals with appropriate qualifications. The DMHCA ensures clinical staff working under their supervision are performing services they are qualified to provided based on education, training, and experience. An interview with the DMHCA indicated she is responsible for providing training to all levels of staff in identifying mental health and substance abuse issues. The DMHCA is responsible for ensuring group, individual, and family therapy is performed in accordance with the contract requirements. The DMHCA is also responsible for completing and overseeing documentation entered into the program's Lauris electronic records system. The DMHCA attends and participates in the formal treatment team meetings, emergency treatment team meetings, transition meetings, and exit meetings. The DMHCA meets with the psychiatrist in a weekly structured meeting regarding each new youth for admissions, for an initial psychiatric evaluation to determine what, if any, psychiatric interventions are needed (i.e. psychotropic medication). The DMHCA indicated the psychiatrist has an open-door policy and is on-site three days a week, allowing the DMHCA, certified behavioral analyst, and mental health therapists to speak with him face-to-face when they have questions or when the need otherwise arises.

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

The program has three full-time licensed mental health counselors (LMHC) and one part-time licensed clinical social worker. The program has a staggered schedule allowing for a licensed clinician on-site every day except for Saturday. Two of the licensed staff are assigned one designated late day working from 12:00 p.m. to 8:00 p.m. one day a week. One LMHC serves as the program's designated mental health clinician authority (DMHCA). The program maintains a current Chapter 397 license through the Department of Children and Families to provide

substance abuse services for outpatient treatment. The program maintains an independent contractor agreement with a licensed clinical social worker who is a certified behavioral analyst (CBA) effective November 12, 2014 with an automatic yearly renewal. The CBA maintains a current license in the State of Florida with an expiration March 31, 2019. The reviewed documentation found each licensed clinician maintained a clear and active license in the State of Florida. The reviewed records demonstrated each staff worked within the scope of their licensure, experience, and training. The DMHCA is on-call for emergencies and consultation twenty-four hours a day, seven days a week.

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

The program has four full-time master's-level non-licensed therapists. All non-licensed clinical staff work under the direct supervision of the Designated Mental Health Clinician Authority (DMHCA) and the Assistant Clinical Director. The DMHCA supervises three licensed therapists, four non-licensed therapists, and the recreational therapist. The program maintains a current Chapter 397 license through the Department of Children and Families to provide substance abuse services for outpatient treatment. The non-licensed clinical staff provide substance abuse treatment and education under the direct supervision of the licensed mental health counselor (LMHC). A review of the clinical supervision log found each non-licensed mental health staff received at least one hour of face-to-face direct supervision from the DMHCA each week. The program also maintained weekly clinical supervision meeting minutes and agendas with training topics and attendance rosters. The reviewed documentation found the clinical supervision log included all required elements, as outlined in Chapter 397, Florida Statutes. The form utilized to document the direct supervision includes all information as outlined on the Department's Direct Supervision Log (MHSA 019) form. The reviewed forms reflected a review of the clinician's competency areas, discussion/focus areas to include clinical case consultation, individual treatment issues and youth-specific focus, and chart audit of all assigned youth. In addition, the reviewed forms documented specific clinical focus areas for each clinician. Training records for non-licensed staff validated three of the four have completed the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included the administration of five Assessments of Suicide Risk (ASR) or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form (MHSA 022). One non-licensed staff was in the process of receiving the required training and documented the completion of one administration of an ASR.

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

The program has a policy and procedures to ensure each youth's mental health and substance abuse needs are identified through a comprehensive screening process, including suicide

prevention. All youth admitted to the program are pre-screened and placed by the Department based upon the individualized history and identified needs of the youth. All youth who present with clinical concerns during the initial mental health or substance abuse screening, or during the course of the program, shall be referred to the licensed mental health staff for a comprehensive mental health and/or substance abuse evaluation. Mental health and substance abuse treatment services are available to all youth in the program and is provided through the provision of mental health overlay services (MHOS). The mental health and substance abuse needs of the 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. Immediately upon each youth's admission into the program, an initial mental health and substance abuse screening process is initiated by the multidisciplinary treatment team to ensure the identification of mental health and substance abuse issues requiring immediate attention and/or further assessment and evaluation. The screening process is designed to gather information on the youth prior to the youth entering the general population. A Facility Entry Physical Health Screening is conducted by nursing staff to assess the youth's immediate medical needs when entering the program. In addition, all youth are administered the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) at the time of admission to ensure the identification of mental health and substance abuse issues requiring immediate attention and/or further assessment and evaluation. Each MAYSI-2 was administered by a trained case management staff in the Department's Juvenile Justice Information System (JJIS). The suicide risk screening process includes the Department's Assessment of Suicide Risk (ASR). Five youth mental health and substance abuse records were reviewed and confirmed the clinical staff reviewed all available information inclusive of the commitment packet, reports, and records of suicide risk, mental health, and/or substance abuse issues. The information was documented on the program's records review form. However, one was documented three days after the youth's admission.

Reviewed documentation supported it is the program's practice to conduct a further evaluation on each youth admitted regardless of the MAYSI-2 results. All five reviewed youth records were referred for further assessment; two were overridden based on the MAYSI-2 results; however, the wrong box was checked. It is the program's practice for each youth to be screened for suicide utilizing the Department's ASR regardless of the MAYSI-2 results, and each youth received a new comprehensive mental health and substance abuse bio-psychosocial evaluation. All five reviewed ASRs indicated each youth was placed on standard supervision with the exception of one. In addition to the MAYSI-2, each youth is assessed upon admission utilizing the Adolescent Substance Abuse Subtle Screening Inventory (SASSI-2), Trauma Symptom Checklist for Children (TSCC), Reynolds Adolescent Depression Scale – Second Edition (RADS-2), Trauma Symptom Inventory, Second Edition (TSI-2), Suicidal Ideation Questionnaire (SIQ) Psychological Assessment, and Structured Assessment of Violence Risk in Youth (SAVRY).

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 maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse services. As part of the evaluation process used to assist in the development of the youth's individualized treatment plan, a comprehensive mental health

and substance abuse bio-psychosocial evaluation is completed. The comprehensive mental health and substance abuse evaluation is an in-depth evaluation involving the gathering of information specific to the youth's mental health, substance abuse, emotional and behavioral functioning, social roles, and other areas which may impact upon the youth's overall level of functioning. Each youth identified through the preliminary screening process is referred for a mental health and substance abuse comprehensive in-depth bio-psychosocial evaluation conducted within thirty calendar days of admission. A review of five youth mental health and substance abuse records found each youth had a completed mental health and substance abuse bio-psychosocial evaluation. Reviewed practice confirmed four of five comprehensive mental health and substance abuse bio-psychosocial evaluation was completed within thirty calendar days of admission. One was completed four days late. Each reviewed bio-psychosocial evaluation contained all required elements, as outlined in Florida Administrative Code 63N-1. All completed evaluations were conducted by a licensed mental health counselor or non-licensed master's-level clinician and was reviewed by a licensed therapist within ten calendar days after the evaluation was conducted. The program maintains a current licensure in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment, effective from April 8, 2018 through April 7, 2019. Reviewed records validated each contained a signed Youth Consent for Substance Abuse Treatment and Youth Consent for Release of Substance Abuse Treatment Records. In addition, the program assesses each youth to elicit insight and understanding in the comprehensive evaluation of the youth utilizing the Trauma Symptom Checklist for Children / Trauma Symptom Inventory (TSCC/TSI), Adolescent Substance Abuse Subtle Screening Inventory, Fourth Edition (SASSI-4), American Society of Addiction Medicine Patient Placement Criteria (ASAM), About My Life / Suicide Ideation Questionnaire (SIQ), Reynolds Adolescent Depression Scale, Second Edition (RADS-2), and Structured Assessment of Violence Risk in Youth (SAVRY). The results of these assessments are incorporated in the individualized comprehensive bio-psychosocial evaluation. As a part of the comprehensive mental health and substance abuse assessment process, each youth admitted on psychotropic medication and/or assessed to be in need of a psychiatric evaluation is referred for a psychiatric evaluation.

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 maintains a written policy and procedures outlining all youth receive mental health overlay services (MHOS) and shall have an individualized mental health and/or substance abuse treatment plan. Mental health and substance abuse treatment is guided by an individualized treatment plan addressing all of the youth's needs in accordance with Florida Administrative Code 63N-1. Treatment is provided by a licensed mental health therapist or a master's-level non-licensed therapist working under the direct supervision of the licensed professional. Each therapist has been trained to perform all services being administered. The Designated Mental Health Clinician Authority indicated individual therapy services are provided biweekly for sixty minutes to all youth in the program. Family therapy services are attempted monthly for sixty minutes to all youth in the program. Group therapy services are provided daily for sixty minutes to all youth and fidelity checks are conducted monthly on group services to

ensure the services are provided in accordance with contractual requirements. A review of five youth mental health and substance abuse records found each youth was assigned to a multidisciplinary treatment team upon admission into the program. Each youth has an initial treatment plan completed by the treatment team on the day of admission which identifies the youth, parent/guardian, mental health/substance abuse therapist, licensed therapist, and other treatment team members. Youth who have been identified with a need of mental health treatment and/or substance abuse treatment receive individual therapy, group therapy, family counseling, a psychiatric evaluation and follow-up treatment, and medication management of prescribed psychotropic medications. Interview with DMHCA validated this practice. Reviewed documentation validated each youth had a properly executed Authority for Evaluation and Treatment (AET) form. Each youth record also had a signed Youth Consent for Substance Abuse Treatment form (MHSA 012), Youth Consent for Release of Substance Abuse Treatment Records form (MHSA 013), Consent for Urine Collection and Analysis, and Youth Have the Right to be Safe from Sexual Violence form. Weekly progress notes found the program documented in the format outlined in Florida Administrative Code 63N-1 and the Department's Counseling/Therapy Progress Note form (MHSA 018). The program practice is to document progress daily on the mental health and substance abuse daily service program record and progress note. Progress notes confirmed each youth is receiving services as stipulated in their treatment plans. A review of the youth records reflected the program provided mental health and substance abuse evaluations and groups, treatment planning, daily group therapy, bi-weekly individual, monthly family therapy (when possible), support services, substance abuse therapeutic activities, psychiatric services, suicide prevention services, and individualized transition services. Individual group therapy is limited to ten or fewer group for youth with a mental health diagnosis and fifteen or fewer youth for a substance abuse diagnosis. A multidisciplinary treatment team was observed during the annual compliance review. Five interviewed staff indicated only therapist facilitate mental health and/or substance abuse groups.

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 maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse services. Mental health and substance abuse treatment services are provided through the provision of mental health overlay services (MHOS). All mental health and substance abuse treatment services provided at the program are provided by or under the direct supervision of the Licensed Mental Health Counselor (LMHC) serving as the Designated Mental Health Clinician Authority (DMHCA). Youth determined to have a mental health and/or substance abuse Diagnostic Statistical Manual of Mental Disorder, Fifth Edition (DSM-5) diagnosis, will have an Initial and Individualized Mental Health and Substance Abuse Treatment Plan. Upon release from the program, all youth will 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. Four of five reviewed youth mental health and

substance abuse records confirmed the multidisciplinary treatment team developed an initial treatment plan on each youth's date of admission to the program. One reviewed youth record documented the initial treatment plan was completed six days after to the youth's admission. The initial treatment plans were documented on a form containing all required elements, as outlined in Florida Administrative Code 63N-1, and on the Initial Mental Health/Substance Abuse Treatment Plan form (MHSA 015). Each of the reviewed plans contained mental health and applicable substance abuse planning for the youth. One of the five reviewed youth records were applicable for admission with psychotropic medications. The reviewed initial plan documented the prescribed medication, dosage, and frequency of monitoring by the psychiatrist. Reviewed initial treatment plans found each was signed by the clinical staff preparing the form as well as the youth, licensed clinical staff, and some treatment team members. The living unit representative, education representative, medical, and parent/guardian were missing signatures. However, the program was able to provide supporting documentation of medical input, direct care input, and education input. There was no documentation to support information was provided prior to the development of the plan and/or telephone communication with the parent/guardian. Five reviewed youth mental health and substance abuse records found each contained a completed Individualized Mental Health and Substance Abuse Treatment Plan developed within thirty days of the youth's admission. One reviewed individualized plan was applicable for psychotropic medications, and documented the prescribed medication, dosage, and frequency of monitoring by the psychiatrist. Each individualized plan reviewed was signed by the clinical staff completing the plan, the youth, licensed therapist, case manager, and some treatment team members. Three of the five were missing the living unit signatures and all five were missing the education representative, medical, and parent/guardian. However, the program has developed medical input forms, direct care input forms, and education input forms. The program was able to provide supporting documentation to validate medical provided a completed form identifying current allergies, medication and dosage, medical grade, and any side effects reported by the youth. The form also documents all upcoming scheduled appointments to include both on-site and off-site. The direct care input form documented the youth's current behavioral review and the current Stages of Change the youth is demonstrating. The education staff submitted a copy of the youth's individualized academic plan, academic transition, and progress notes. There was no documentation to support information was provided by the parent/guardian prior to the development of the plan and/or telephone communication with the parent/guardian. The program's certified behavioral analyst has a caseload of three youth for Dade Youth Academy and a caseload of seven for Dade Juvenile Residential Facility. A review of the three youth records for Dade Youth Academy found each youth had a behavioral plan in place. Monthly summaries documenting overall progress and summary of intervention procedures were maintained and were incorporated into the formal treatment team discussion and findings for each youth. The psychiatrist meets with the DMHCA and clinical staff every week to discuss medication adjustments and treatment. Attendance logs and minutes are maintained for each meeting to include the diagnosis and rational for any applicable changes and discussion and meeting outcome results. Reviewed documentation confirmed each youth receives an individualized mental health and substance abuse treatment plan review at least every thirty days, which is documented on the Individualized Mental Health Treatment Review form (MHSA 017). One youth had one of three applicable reviews conducted three days late. The program reported it was due to the Christmas holiday and the schedule was not adjusted to ensure the youth met the thirty-day timeframe. A review of five mental health and substance abuse treatment discharge summaries found each documented the youth's relevant mental health and substance abuse history and reason for recommending on-going treatment. Each reviewed record contained a completed discharge plan documented on the Mental Health/Substance Abuse Treatment Discharge Plan form (MHSA 011), which was available during each youth's

exit staffing. The issues which were the focus of the mental health and/or substance abuse treatment were identified, as well as the summary of the youth's progress in treatment while participating in the program. Each reviewed discharge summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. There were no applicable youth released with an identified suicide risk alert. Each reviewed discharge summary contained recommendations for continuing mental health and/or substance abuse treatment within their home community including any applicable referrals for continued services. The discharge summaries were discussed with the youth and parent/guardian and assigned juvenile probation officer (JPO) at the exit conference and a copy was sent electronically to the 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.".	

A review of the program's contract and clinical program description indicated mental health and substance abuse treatment services are available through the provision of mental health overlay services (MHOS). Each youth is assessed upon admission for mental health and substance abuse utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). All five reviewed ASRs indicated each youth was placed on standard supervision. In addition, the program assesses each youth to elicit insight and understanding in the comprehensive evaluation of the youth utilizing the Trauma Symptom Checklist for Children / Trauma Symptom Inventory (TSCC/TSI), Adolescent Substance Abuse Subtle Screening Inventory, Fourth Edition (SASSI-4), American Society of Addiction Medicine Patient Placement Criteria (ASAM), About My Life / Suicide Ideation Questionnaire (SIQ), Reynolds Adolescent Depression Scale, Second Edition (RADS-2), and Structured Assessment of Violence Risk in Youth (SAVRY). The results of these assessments are incorporated in the individualized comprehensive bio-psychosocial evaluation. The program's specialized mental health and substance abuse treatment services include bi-weekly individual therapy sessions and monthly family therapy sessions. In addition, mental health treatment groups and substance abuse groups are provided seven days a week to include group process therapy, anger management groups, conflict resolution, clinical education group forums, and other psycho-educational training groups. Supportive counseling is provided on an as-needed basis. All specialized mental health treatment services are provided by licensed and master's-level therapists. The program has a full-time licensed mental health counselor serving as the Designated Mental Health Clinician Authority (DMHCA) working forty hours a week and is on-call twenty-four hours a day, seven days a week. The program has three full-time licensed clinicians; two licensed mental health counselors (LMHCs), and one part-time licensed clinical social worker (LCSW). In addition, the program has four master's-level non-licensed therapists. The program maintains an independent contractor agreement with a State of Florida board-certified licensed psychiatrist providing on-site services. The psychiatrist is on-site three days weekly for approximately twenty-four hours. A review of five youth mental health and substance abuse records validated each youth received individualized mental health services and substance abuse services. Youth participate in group daily, seven days a week. Groups offered include mental health and substance abuse services.

3.09 Psychiatric Services (Critical)	Satisfactory Compliance
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C.	

The program has an independent contractor agreement with a State of Florida, board-certified, licensed psychiatrist. The program does not utilize an advanced registered nurse practitioner (ARNP). Reviewed written psychotropic medication management policy and procedures validated the psychiatrist reviewed and approved the policy and procedures on November 26, 2018. A review of the psychiatric visitor log confirmed the psychiatrist has been on-site at least three times a week during this annual compliance review period and is available for emergencies and consultation twenty-four hours a day, seven days a week. The psychiatrist, designated mental health clinician authority (DMHCA), and therapists meet weekly to discuss and review each youth receiving psychotropic services and their progress. An interview with the psychiatrist indicated he evaluates new patients and follow-up with approximately seven to eight youth each day he is on-site. While on-site, the psychiatrist participates in pharmacy meetings, daily nursing meetings to discuss each youth's condition, compliance with medication, and discharge follow-up plans. In addition, the psychiatrist indicated he makes informal calls to parents/guardians and Department of Children and Families case workers to discuss informal concerns. The psychiatrist indicated he meets weekly with all clinical staff to discuss each youth receiving treatment, discuss overall progress, and medication treatments. The psychiatrist includes meetings with the on-site school teachers to discuss school progress and with direct care staff to discuss youth behaviors. While in the dorm, the psychiatrist will also speak to the youth. A review of five youth mental health and substance abuse records indicated one youth was admitted to the program prescribed psychotropic medications. The program practice is for all youth to be referred for a psychiatric evaluation. Reviewed practice supported each youth received a psychiatric evaluation within fourteen days of admission. Two youth were prescribed psychotropic medications after admission. Each youth's psychiatric evaluation was documented on the Department's Clinical Psychotropic Progress Note (CPPN) and program-specific form, which were completed within the required timeframe as outlined in policy. All three youth prescribed psychotropic medications received medication reviews at least every thirty days. The parent's/guardian's verbal consent for psychotropic medication was documented through the CPPN (form HS 006) on page three, and written consent was documented on the Acknowledgment of Receipt of CPPN Form or Practitioner Form (HS 001), in accordance with Rule 63N-1.0085, Florida Administrative Code. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. The Chapter 397 license is effective from April 8, 2018 through April 7, 2019. The program maintains an independent contractor agreement with a State of Florida board-certified licensed psychiatrist effective December 8, 2008 with an automatic yearly renewal. The psychiatrist is scheduled to be on-site three days a week, for approximately eight hours each day, for a total of twenty-four hours a week. The psychiatrist is scheduled to be on-site on Monday, Tuesday, and Thursday Interview with the psychiatrist validated he is on-site three days weekly and provides evaluations and medication management. The psychiatrist indicated he has no concerns with the healthcare provided at the program.

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

The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedures. The MHSA plan was last updated and approved by the facility administrator and the designated mental health clinician authority (DMHCA) on January 3, 2019. The program's written plan detailed suicide prevention procedures and included all required elements as outlined in Rule 63N-1, Florida Administrative Code. The plan outlined the identification and assessment of youth at risk of suicide through the screening or alert process and any time subsequently, as well as suicide precautions and the levels of supervision. The plan addressed the requirements for staff training as it relates to suicide prevention, the implementation of suicide precautions, and to recognize verbal and behavioral cues. The plan included the referral process, communication, notification, documentation, immediate staff response, and review process. An interview with the DMHCA and the Facility Administrator indicated the program provides suicide prevention training throughout the year and conducts monthly mock emergency mental health drills to include emergency response to suicide attempts or self-inflicted injury.

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 maintains a written comprehensive suicide prevention plan to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The suicide prevention plan was last updated by the program on September 10, 2018. The program maintains three complete suicide response kits which are located in each sub-control. Observations during the annual compliance review confirmed each kit contained the knife-for-life, wire cutters, and needle nose pliers. The program's suicide prevention plan outlines an established review process for the Facility Administrator and licensed mental health therapist to review each Suicide Precautions Observation Log and track the frequency and proper implementation of precautionary observation (PO). They must review the logs to determine whether the use of suicide precautions was appropriate for each instance and shall initiate corrective action to address any deficiencies in implementation of suicide precautions. A review of five youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's Assessment of Suicide Risk (ASR) to determine if the youth had elevated suicide risk factors. All five completed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. The program indicated they had two applicable youth who returned to from court and were placed on PO until an ASR was completed. A mental status examination was completed in addition to the follow-up

ASR. Each youth was subsequently placed on close supervision and then standard supervision. The program had no other documented practice of placing a youth on suicide precautions since the last annual compliance review. The program does not utilize secure observation. The reviewed training records for the non-licensed therapist validated three of the four completed the required twenty hours of training and five supervised assessments completed under the direct supervision and within the presence of the licensed mental health clinician. One therapist was in the process of completing the required training. Program staff are to make a referral for clinical services for each youth placed on PO and each youth is to remain on PO until the ASR is completed. While on PO program staff will maintain Suicide Precautions Observation Logs. Precautionary observation has to be authorized for each youth and follow-up ASRs need to be completed for each youth prior to the removal of PO. While on PO, mental health staff provide supportive services as reflected on the Suicide Precautions Observations Logs. The licensed therapist and the facility administrator documented their communication prior to stepping down the youth's level of supervision and the program's logbooks document when youth are placed on PO and when they are stepped down to less restrictive supervision. Youth placed on any elevated level of supervision due to suicide risk had an alert placed in the program's internal alert system, program logbook, and the Department's Juvenile Justice Information System (JJIS) and subsequently removed when the alert was no longer warranted. The program utilizes Jackson Memorial Hospital in Miami, Florida, Citrus Health Network Inc. in Hialeah, 'Florida, or Community Health of South Dade, Inc. in Cutler Bay, Florida for emergency mental health evaluation and crisis stabilization treatment. Five interviewed staff indicated when a youth expresses suicidal thoughts, direct care staff are responsible for notifying mental health and supervisory staff, place the youth on constant sight and sound, and document supervision. Staff were also able to indicate the program has a suicide response kit located in each dormitory.

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 maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a suicide prevention plan to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The MHSA plan and suicide prevention plan were last updated by the program on September 10, 2018.
A review of five youth mental health and substance abuse records found none were applicable for precautionary observation (PO). Two additional applicable youth records whereby the youth returned from court were placed on PO until the Assessment of Suicide Risk (ASR) could be completed. The program had no other documented practice since the last annual compliance review. The reviewed Suicide Precaution Observation Logs found they were maintained for the duration youth was on suicide precautions. Reviewed logs documented the safe housing box with a check. Program policy and procedures indicate all areas are considered safe housing including but not limited to the day areas, cafeteria, recreation areas, classrooms, and bathrooms. Interview with the designated mental health clinician authority and a youth placed on precautionary observation validated the practice. All designated observation areas are regularly inspected through shift-to-shift safety and security checks and through searches of the areas documented by the shift manager on the suicide precautions log sheet. Youth on PO sleep in the hallway outside their sleeping room. The level of supervision and observations of youth's behavior were documented in real time. There were no behavioral warning signs applicable for

documentation. Each shift supervisor and mental health staff signed the Suicide Precautions Observation Logs daily.

3.13 Suicide Prevention Training (Critical)	Limited 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.	

A review of seven training records of direct care staff, supervisory staff, mental health and substance abuse licensed and non-licensed staff, and nursing staff validated each staff had received at least six hours of annual training in suicide prevention and implementation of suicide precautions. Training was conducted face-to-face by the program's staff, as well as online in the Department's Learning Management System (SkillPro). The program includes the training in both the pre-service and in-service training plans. The requirement is for all staff with direct contact, on a day-to-day basis with youth, must participate in at least one quarterly mock drill semi-annually. A review of the program's suicide/mental health drills for the past year found the drills were not conducted quarterly on each shift. One drill in April 2018 of a cutting, two drills were conducted on A-shift in September and simulated a youth drinking bleach, one in November and one in December 2018 of a hanging where staff simulated using cardiopulmonary resuscitation (CPR) and utilizing the automated external defibrillator (AED). Drills conducted on B-shift included one in September; however, there was no clear indication of what the drill was for. B-shift also conducted CPR/AED simulated drills in February, March, November and December 2018. Drills conducted on C-shift documented one in September 2018; however, there was no clear indication of what the drill was for. A drill in January 2019 was for a cut arm and one in November with the simulated use of CPR/AED for an attempted hanging. There was one documented drill conducted in December whereby a youth drank paint; however, there was no time noted to indicate what shift participated. There were no documented drills conducted June, July, and August 2018. Staff members who participated in the drills signed the facility drill signature sheet. Interview with the facility administrator indicated the program provides training or mock drills for staff, which include emergency response to suicide attempts or self-inflicted injury monthly or quarterly.

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 in place to respond to youth in crisis in the least restrictive method possible, and to protect the safety of the youth and others while maintaining control and safety of the facility. Low level crisis intervention is typically provided by direct care staff and/or supervisory staff through interventions within the behavior management system or by therapeutic interventions. In some instances, a youth's acute emotional or behavioral problem or psychological distress is extreme and does not respond to ordinary crisis intervention. In these instances, referrals to the mental health therapists are required. Crisis intervention is provided as needed in a one-to-one setting for youth who require immediate processing related to the specific incident. Crisis intervention may be provided for, but is not limited to, anger control issues, depressive symptoms, threats of harm toward others,

maladaptive coping mechanisms, and impaired impulse control. The program maintains a written crisis intervention plan, reviewed, approved, signed, and dated by the Designated Mental Health Clinician Authority on January 3, 2019. The plan detailed crisis intervention procedures to include notification and alert system, means of referrals, including youth self-referral, communication, supervision, documentation, and review process.

3.15 Crisis Assessments (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, or by a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the 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.	

A review of five youth mental health and substance abuse records found no youth was applicable for crisis intervention. Interview with program staff indicated the program had two applicable incidents since the last annual compliance review whereby the youth were determined to be in crisis and a crisis assessment was conducted. A review of two applicable youth records supported the program's regional psychologist conducted a crisis assessment and both youth were subsequently placed on constant supervision. Each reviewed crisis assessment included the reason, mental status examination, interview, determination of day to self and others, initial clinical impressions, supervision recommendation, treatment recommendations, and recommendations for follow-up or further evaluation. Both crisis assessments documented the youth's parents/guardians were notified the same day the crisis assessment was completed. Both youth documented constant supervision and the supervision logs were maintained for the duration each youth was on heightened observations. A follow-up mental status examination was conducted by a master's-level non-licensed therapist and each was reviewed by the licensed clinical social worker. Both youth remained on constant supervision for four days.

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

The program had a policy and procedures in place regarding emergency response plan. The program defines a mental health or substance abuse emergency as a youth who presents as an imminent danger to himself or others because of mental illness or substance abuse impairment requiring emergency treatment. The program maintained a written emergency mental health and substance use services plan, which was last revised and approved by the Designated Mental Health Clinician Authority (DMHCA) on January 3, 2019. The emergency care plan included procedures for emergency identification and immediate staff response, supervision, authorization of transport for emergency services and transportation for mental health and substance abuse emergencies, documentation, review, and staff training. The plan contained all

the elements required by Florida Administrative Code 63E-7 and 63N-1. An interview with the DMHCA indicated there were no youth applicable for emergency mental health and/or substance abuse services for this annual compliance review period. The plan outlined transport for emergency mental health evaluation and treatment for Baker Act to either Citrus Health Network, Inc. in Hialeah, Florida for youth fourteen to seventeen years of age, or Community Health of South Dade, Inc. for youth eighteen years of age and older. The program utilizes Jackson Memorial Hospital in Miami, Florida for Marchman Act proceedings in the event a youth is identified with detoxification symptoms. All staff have the right to immediately contact 9-1-1 and have access to rescue tools in case of an emergency.

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

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

Standard 4: Health Services

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

The program has an independent contractor agreement with a licensed medical doctor (MD) signed July 24, 2012. Review of documentation found the MD's license issued by the State of Florida Department of Health (DOH), Division of Medical Quality Assurance is valid through January 31, 2020. The MD's training is in pediatrics and surgery. The MD serves as the Designated Health Authority (DHA) for the program and provides on-site services once a week. Review of sign-in/out logs from June 24, 2018 to February 25, 2019 found the DHA was on-site weekly. Each documented on-site visit was four hours in duration. The DHA is responsible for communication with facility staff regarding youth medical needs and is available electronically twenty-four hours a day, seven days a week for acute medical concerns, emergency care and coordination of off-site care. The program has a separate agreement signed July 13, 2017, with a State of Florida licensed physician to provide coverage in the absence of the DHA. Interview with the DHA confirmed they provide weekly on-site services to the program and are available electronically by cell phone twenty-four hours a day, seven days a week. In addition, the DHA reviews nursing protocols and facility policies and procedures. The DHA is responsible for the overall clinical healthcare services provided to youth in the program.

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

The program has a written policy and operating procedures to address all health-related procedures and protocols utilized. Policies and procedures are reviewed by the Facility Administrator (FA) and the Designated Heath Authority (DHA) upon implementation and annually thereafter. A review of documentation found the DHA last reviewed policies and procedures on July 9, 2018 as documented on the policy and procedures review form. The newly hired FA signed off on the policies effective September 10, 2018. Corporate office approved the established policies on July 10, 2017. Nursing staff signed and dated a cover page listing all facility operating procedures and protocols reviewed on July 25, 2017, July 9, 2018 and a newly hired nursing staff signed in January 10, 2019. Review and development of facility operating procedures and protocols related to psychiatric services and psychotropic medication management was performed by the program's psychiatrist. The psychiatrist last reviewed psychotropic medication management policy and procedures on November 26, 2018. Review of staff training found two new health care staff were hired and received orientation training as verified by the completed on the job training plan.

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

The program has a written policy and procedures to ensure a signed and dated Authority for Evaluation and Treatment form (AET) is maintained in each youth individual healthcare record (IHCR) . The AET serves as informed consent for non-invasive medical procedures or minor

ailments requiring over-the-counter medication. The AET is signed by the parent/guardian for youth under the age of eighteen years. Youth eighteen years of age can sign the Release of Information Authorization Form for Youth 18 Years of Age and Older to provide consent. A review of five youth records found three of five records contained an original AET form filed in the youth's IHCR. Two of five youth records contained a legible copy of the AET with the word "copy" stamped on the AET form. Two of five youth records reviewed had the Release of Information Authorization Form for Youth 18 Years of Age and Older. One of the two youth records documented the authorization for release was only for emergency notification. Copies of parental notifications were available in each youth record. None of the records reviewed indicated youth were in the care of the Department of Children and Families (DCF).

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

The program has a written policy and procedures to ensure the parent/guardian is advised of any significant changes in the youth's condition and to obtain consent when new medication and treatments are prescribed. A review of five youth individual healthcare records found a list of over-the-counter (OTC) medications approved by the Designated Healthcare Authority (DHA), was forwarded to each youth's parent/guardian. Reviewed youth records were not applicable for prescription of OTC medications beyond those covered in the Authority for Evaluation and Treatment (AET), vaccinations or immunizations not consented for on the AET, significant changes to existing medication or discontinuation of medication prescribed to youth prior to entering the program. Two youth records were applicable for changes in condition and medication. Each of the two youth began psychotropic medication after their admission to the program. One of the five youth records reviewed was admitted to the program with established psychotropic medication in place. No changes in mediation were made for this youth. Two of five youth records documented youth had invasive procedures. Of these, each youth had dental procedures. Two of five youth records documented youth received off-site emergency care at the hospital. Of these, one youth was seen post-seizure and the other for a shoulder sprain. Each youth returned to the program the same day. Documentation of verbal and written notifications to the youth's parent/guardian was maintained in each applicable youth record. Interviews with nursing staff and the healthcare services administrator confirmed immunization records for youth are obtained through Florida Shots and through contact with the youth's school. Immunization records are reviewed on the day of admission.

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

The program has a written policy and procedures to ensure the parent/guardian is contacted to obtain consent for newly prescribed psychotropic medications, discontinuances, or medication adjustments. All attempts to contact the parent/guardian are documented in the youth individual healthcare record (IHCR). A review of five youth IHCRs found three records applicable for the prescription of psychotropic medication. One youth admitted to the program with prescribed psychotropic medication. Two youth were prescribed psychotropic mediation after their admission to the program. Each record documented verbal notification to the parent/guardian witnessed by a staff member. Written notification was mailed to the parent/guardian for each applicable record along with a copy of the Clinical Psychotropic Progress Note (CCPN) for

consent and explanatory information regarding the medication. A review of youth IHCRs found CCPN's were not signed by the parent/guardian and returned to the program. Records reviewed found none of the youth were in the care of the Department of Children and Families (DCF).

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

The program has a written policy and procedures to ensure an immunization history is obtained for each youth admitted to the program. A review of five youth individual healthcare records found each contained an immunization history. Four youth records documented immunization status obtained by the nurse on the Florida Certification of Immunization form through Florida Shots. One youth record documented immunization status on the clinic card obtained from the youth's school. Each record contained a Department Immunization Tracking Record (HS016). Documentation in each youth record supported the nurse reviewed youth immunization status on the date of admission. Immunizations were current for each youth record reviewed. Interview with the health services administrator found any youth requiring additional vaccinations would obtain them through the Department of Health (DOH). There were no applicable youth with a filed religious exemption from immunizations.

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

The program has a written policy and procedures to ensure youth receive routine healthcare screening and evaluation upon admission. A review of five youth individual healthcare records found each received a healthcare screening on the day of admission as documented on the Facility Entry Physical Health Screening Form (FEPHS) form. Each screening was completed by the registered nurse (RN).

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

The program has a written policy and procedures to ensure all staff are advised of identified medical or mental health issues which may affect the security and safety of the youth in the facility. A review of five youth records and the internal alert system found youth conditions were updated accurately and placed on the medical alert roster to include chronic conditions, mental health alerts, allergies and dietary restrictions. Interview with the Health Services Administrator explained nursing was responsible for updating alerts daily and for providing updated alert information to staff. Three youth were identified with prescribed psychotropic medication. Of these, one youth had scoliosis, and one had vision impairment. One youth was identified with vision impairment and dietary restrictions. One youth was identified with seasonal allergies and a history of asthma. Interviews with nursing staff and the Healthcare Services Administrator indicated nursing staff review youth alerts daily. Nursing staff distribute alerts to staff daily and update staff regarding any changes to alerts as they occur. Alerts were removed or updated as required in the Department's Juvenile Justice Information System.

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

The program has a written policy and procedures to ensure youth are oriented to the healthcare system upon admission. A review of five youth individual healthcare records (IHCRs) verified each youth received healthcare orientation on the date of admission to include review of access to medical care, sick call, what constitutes an emergency, when to notify staff, medication process, right to refuse care, what to do in the case of sexual assault or attempted assault, and the non-disciplinary role of health care providers. Youth also received information regarding accident prevention, hygiene, adolescent development, dental care, nutrition, eating disorders, self-esteem, dehydration, alcohol abuse, coping with anger, anxiety reduction, family planning, smoking cessation, cardiovascular health, sexually transmitted infections, family planning, Hepatitis B and C, human immunodeficiency virus (HIV), tuberculosis, testicular self-examination, breast self-examination and immunizations. Youth and nursing staff sign the health education packet. All information was documented and maintained in the youth IHCR.

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

The program's practice is to notify the Designated Health Authority (DHA) by telephone for all admissions. Nursing staff document notification to the DHA on the DHA Notification of Admission form. The form is signed by the nurse and is subsequently signed by the DHA after review. A review of five youth records verified this practice.

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

The program maintains a written policy and procedures to ensure healthcare admission rescreening is completed each time there is a change in the physical custody of the youth and they are readmitted or returned to the program. A review of five youth records found a change in physical custody occurred for two youth. An additional record was selected for review and was applicable for a physical change in custody. A review of the Department's Facility Entry Health Screening (FEPHS) form found each youth received a healthcare admission rescreening completed by the registered nurse (RN) upon return the program.

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

The program has a written policy and procedures to ensure nursing staff complete the Department's Health Related History (HRH) form prior to completion of the Comprehensive Physical Assessment (CPA). A review of five youth individual healthcare records found each youth HRH was completed on the date of admission. Each HRH was completed by a registered

nurse (RN) in advance of the CPA. The RN and designated health authority (DHA) signed and dated the HRH acknowledging their review.

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

The program has a written policy and procedures to ensure each admitted youth receives a physical health evaluation. A review of five youth individual healthcare records found each contained a copy of the Department's Comprehensive Physical Assessment (CPA) form. Four youth records contained a CPA on file at the time of the youth's admission. One youth record documented a CPA was completed within seven calendar days of the youth's admission to the program. Of the five youth records reviewed, each youth record documented the CPA was completed by the Designated Health Authority (DHA). Each CPA documented the youth's medical grade and documented all sections of the CPA were addressed utilizing an "O" or an "X". Two youth records documented youth refusal of the Tanner Stage examination. In each instance, youth signature of refusal was documented on the CPA. The Department's Problem List was updated in each youth record.

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

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

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

The program has a written policy and procedure to ensure youth receive a routine healthcare screening evaluation for tuberculosis. A review of five youth individual healthcare records (IHCRs) found each record contained a copy of a tuberculosis screening test (TST) within the last year. The Department's Facility Entry Health Screening (FEPHS) form is used to conduct a tier I tuberculosis screening and is maintained in each youth's IHCR. Screening is completed within seventy-two hours of admission. Results of the TST are documented on the Comprehensive Physical Assessment (CPA) and the Department's Infectious and Communicable Disease (ICD) form. Each youth was assessed for symptoms suggestive of active tuberculosis prior to placement in general population. A review of five youth records found no documented positive TST results.

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

The program has a written policy and procedures to ensure all admitted youth are clinically screened and evaluated for sexually transmitted infections (STI). A review of five youth individual healthcare records found each youth was sexually active and was clinically screened and evaluated for STI's. Screening results were documented on the Department's Sexually

Transmitted Infections Screening form (HS029). Each youth was referred to the Designated Health Authority (DHA) for further evaluation. Testing was ordered and performed for each youth and respective lab results were documented in each youth record. There were no youth out of the Department's custody for over thirty days and/or requiring a rescreening due to symptoms.

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

The program has a written policy and procedures to ensure all at risk youth for human immunodeficiency virus (HIV) infection are offered counseling, testing, and referrals for medical treatment. A review of five youth individual healthcare records (IHCRs) found each youth was offered the opportunity for counseling, testing and a treatment referral for HIV. Three of five youth received testing, two youth documented their refusal for testing. The Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form (HS015) was maintained in the records of youth who consented for testing. Pre-counseling, post-counseling and testing was performed by Union Positiva, Inc. Pre-test and post-test counseling was documented in the youth IHCR. HIV results were filed in a sealed envelope and marked as 'confidential' with the youth's name documented on the outside of the envelope. The youth HIV status is not documented as part of the internal alert system. Five youth were interviewed regarding whether they could ask for an HIV/Aids test. Each youth reported they could ask for an HIV/Aids test.

4.18 Sick Call Process – Requests/Complaints	Satisfactory Compliance
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.	

The program has a written policy and procedures to ensure youth can make sick call requests and have their complaints appropriately addressed through the sick call system. Youth may place a sick call seven-days a week. Sick call hours are posted outside of the medical office and youth are informed of the sick call process during their orientation to the program. Sick call hours are conducted daily by the nurse from 2:00 p.m. to 4:00 p.m. and the nurse is on-site at the program daily until 10:00 p.m. to address any sick calls which occur outside of regularly scheduled sick call hours. In the absence of the nurse, supervisory staff review submitted sick calls requests no longer than two hours after the sick call request is made and contact the Health Services Administrator to receive direction regarding youth complaints. A review of five youth records found three youth presented for sick calls. One youth placed two sick calls, one youth placed three sick calls, and one youth placed eight sick calls. None of the applicable youth presented for a similar sick call compliant three or more times within a two-week period. Five youth were interviewed regarding how quickly they could see a nurse once a sick call request was made. Four youth replied they could see a nurse within one day and one youth reported they could see the nurse immediately.

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

The program has a written policy and procedures to ensure youth can make sick call requests and have their complaints appropriately addressed. A review of five youth individual healthcare records (IHCRs) found three youth submitted sick call requests during their stay. Sick call is completed by the registered nurse (RN). Both the youth and RN document their signature on the Sick Call form. Completed Sick Call forms are filed with progress notes in reverse chronological order within the youth's IHCR. Sick calls are recorded on the Sick Call Index form (HS032) and the Sick Call Referral Log form (HS031). An observation of sick call conducted by the RN during the annual compliance review week found the youth's privacy was ensured. The youth was escorted to the medical clinic by a direct care worker who stood outside of the door. The youth was seated on the examination table. The youth was evaluated for a toothache and received an examination including vital signs, education, and treatment. Five youth were interviewed regarding how quickly they could see a nurse once a sick call request was made. Four youth replied they could see a nurse within one day and one youth reported they could see the nurse immediately. Five staff were interviewed and asked who conducts sick call and each reported the nurse conducts sick call.

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

The program does not use restricted housing, confinement, seclusion, room restriction, or secure observation; therefore, this indicator is rates non-applicable.

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

The program has a written policy and procedures to ensure the implementation of a written plan providing twenty-four-hour emergency medical, dental and mental health care to youth. The program also maintains a written policy and procedures to ensure the program based automated external defibrillator (AED) is properly managed and distributed to youth eight years of age and older who display all symptoms of cardiac arrest. A review of five youth individual healthcare records (IHCRs) found four youth received episodic and/or first aid care. Three youth each had a total of three incidents of care and one youth had a total of four incidents of care. One youth did not require episodic care or first aid. Nursing staff provided treatment in each instance and documented services on the progress note maintained in each youth IHCR. Notes included the date and time of episodic care, nature of the complaint, findings of the person rendering care, treatment rendered, education provided to youth and the printed name and credentials of the staff providing care. Progress notes documented services provided in problem-oriented subjective, objective, assessment and plan (SOAP) elements. An episodic/first aid emergency care log was maintained by nursing staff to document all incidents of care and respective outcomes. The program has one AED unit located in master control, three suicide response kits containing a knife-for-life, wire cutters and needle nose pliers located in each dormitory staff sub control unit and seven first aid kits. The first aid kits are checked weekly by the registered nurse (RN) and the AED unit is checked monthly to ensure functionality. Five

youth were interviewed and asked if they could see a dentist of they had tooth pain. Two youth responded they could not and three youth reported they would be able to see a dentist for tooth pain. Each youth reported they could see a doctor if needed.

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

The program has a written policy and procedures to ensure there is a written plan to implement twenty-four-hour emergency medical, dental and mental health services as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. The program maintains a written policy and procedures to ensure the automated external defibrillator (AED) is properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. The program has one AED unit located in master control. Nursing staff conduct monthly checks to ensure the AED is functioning properly. The operating instructions are located on the AED and a user is additionally prompted with audible automated instructions once the device is powered on. The master control operator demonstrated the AED and validated it was in working order. The AED battery expires in September 2020 and was last changed in April 2016. The AED pads expire in July 2019. Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. The registered nurses (RN) each maintained current certifications in CPR/AED and basic first aid. Suicide response kits containing a knife-for-life, wire cutters, and needle nose pliers are maintained in the staff office sub control area on each dormitory. First aid kits are located in each dormitory office, master control, school, and in vans one and three. Observations during the tour of the program found postings informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were maintained in master control and the medical clinic. Reviewed documentation found the program conducted a CPR/AED drill five times on the second shift, and seven times on the first and third shifts in the last twelve months. Six staff were interviewed regarding whether they could call 9-1-1 if youth had a medical emergency. Three staff reported they could call 9-1-1, one staff reported they could call but typically go through a step process first notifying the facility administrator (FA) to see if a 9-1-1 call should be made, one staff reported not having access to a phone and a code white would be called and master control would be alerted, one staff reported they could not call 9-1-1 and would notify medical staff and the supervisor if there was a medical emergency.

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

The program has a written policy and procedures to ensure evaluations conducted off-site are recorded on the Department's Summary of Off-Site-Care Form (HS033). A review of five youth individual healthcare records found two youth were seen off-site for emergency care. A third applicable record was not available. One youth was seen off-site for post seizure activity and the other youth was seen for a shoulder sprain. Each youth record contained a completed Summary of Off-Site Care form and applicable discharge instructions. The Designated Health

Authority (DHA) reviewed and signed all off-site care findings, instructions, and information. Follow-up testing and referrals were not required for either youth.

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

The program has a written policy and procedures to ensure youth identified with a chronic illness receive regularly scheduled evaluations and necessary follow-up treatment. A review of five youth individual healthcare records (IHCRs) found each youth was identified with a chronic condition and classified with a medical grade of two through five. One youth was undergoing treatment for a physical health condition, which included a body mass index (BMI) greater than thirty. The program maintains a roster of youth requiring periodic evaluations and the condition for which they are being treated. A review of youth IHCRs found youth were receiving periodic evaluations as required. There were no documented lapses in care. Four out of five youth records documented youth were taking medication on an on-going basis. The Department's Problem List form (HS026) was updated as required for each applicable youth. The Facility administrator (FA) was interviewed regarding what formalized procedures are in place with the healthcare staff to review important medical issues pertaining to youth. The FA reported meetings occur on a daily, weekly and monthly basis to ensure the communication of medical issues and concerns. Interview with the Designated Health Authority (DHA) indicated staff and the DHA maintain a calendar to ensure periodic evaluations of youth occur as required. The DHA reported chart audits are also conducted by staff to ensure adherence to the schedule.

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

The program has a written policy and procedures to ensure medical staff verify any medication arriving with newly admitted youth and continue all currently prescribed medications. Healthcare staff conduct a preliminary assessment and interview with newly admitted youth to verify medication. The Designated Health Authority (DHA) is notified regarding all youth admissions. A signed Authority for Evaluation and Treatment (AET) is completed to continue and administer current medication as ordered. A review of five youth individual healthcare records (IHCRs) found one youth was taking medication upon admission to the program. One additional applicable record was available and selected for review. Each record supported established practice for verification of medication. Interview with the Health Services Administrator indicated program practice is to forward original IHCRs to the youth's juvenile probation officer (JPO) upon release from the program.

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

The program has a written policy and procedures to ensure all medications have a current, valid order and are given pursuant to a current prescription or practitioner's order. A review of five youth individual healthcare records found four youth were applicable for medication management. Each youth record documented a current valid prescription order. One youth was admitted to the program with prescribed medication. Each applicable record documented

prescribed medication was continued, changed, or a new medication was ordered. No discontinuation of medication was noted in the records reviewed. Over-the-counter medication was administered pursuant to the physician's order.

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

The program has a written policy and procedures to ensure all medications are stored in separate, secure, locked areas inaccessible to youth. Observation of the medical clinic found medications were secured and stored in a locked medication cart and locked designated cabinets throughout the clinic. Non-controlled medications were stored in the medication cart and controlled medications are stored in a locked box within the locked medication cart. Oral medication was stored separately from topical medication. The program had no applicable medication requiring refrigeration during the annual compliance review week. Sharps and syringes were stored securely and separate from medication. The program has a written established process for the disposal of expired and discontinued medication. All controlled medication is disposed of by the consultant pharmacist using the Rx Destroyer and witnessed by the registered nurse (RN). Disposal is documented on the True Core Behavioral Controlled Medication Inventory Record. All unused medications are sent back to First Choice Pharmacy for credit. The program has a designated vendor for the disposal of medical waste.

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

The program has a written policy and procedures to ensure all medication and sharps are stored securely, inventoried regularly, disposed of and properly maintained in accordance with federal and state laws. Over-the-counter (OTC) medications are inventoried using a perpetual inventory and is verified weekly by registered nursing (RN) staff. Reviewed documentation from July 2018 through February 2019 verified OTC medication is inventoried on a weekly basis. Perpetual inventories with running balances are maintained for all controlled substances with a shift-to-shift inventory conducted by two RN's. Upon completion of the inventory of both controlled and non-controlled medications, there were no discrepancies found A perpetual inventory for sharps and syringes is maintained and counted weekly. The program contracts with First Choice Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and monthly inspection report. In addition, the consultant pharmacist conducts a quarterly interdisciplinary risk reduction and quality improvement meeting with the Facility Administrator (FA), Health Services Administrator, Designated Health Authority (DHA), and the designated mental health clinician authority to discuss risk reduction measures, trends in medication treatment errors, medication errors, mock emergency drills, youth chronic conditions and psychotropic medications. The last meeting was held on February 6, 2019.

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

The program has a written policy and procedures to ensure all controlled substances shall be inventoried, stored and documented as required by the Board of Pharmacy and Department requirements. All controlled substances are housed in a locked box maintained within the locked medication cart in the medical clinic and are inaccessible to youth. Youth individual controlled medication inventory records are updated after each medication administration. There were no applicable youth prescribed controlled medication during the annual compliance review week. A review of documentation found the program maintains a Modified Institutional Class II Type B permit with an expiration date of February 28, 2021. Nursing staff are on-site seven days a week until 10:00 p.m. Non-licensed shift managers are trained to administer over-the-counter medication (OTC) when nursing staff are not on-site. In addition, the Assistant Facility Administrator and unit manager are trained to administer OTC medication in the absence of nursing personnel.

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

The program has a written policy and procedures to ensure medications shall be provided pursuant to a physician order housed in the youth's individual healthcare record (IHCR) or pursuant to a youth's current prescription container if youth medications are administered from a container with a current patient-specific label and verified by nursing staff. A review of five youth IHCRs found one youth was admitted to the program with established prescribed medication. An additional applicable youth record was available reviewed. A review of each youth record found the program utilizes a pre-printed First Choice Pharmacy Medication Administration Record (MAR) to document medication administration. Each MAR documented the youth's name, Department identification number, date of birth, youth allergy status, precaution status, medical grade and a picture of current youth. A review of the initial MAR supported the youth received medications as ordered. The MAR documented start and stop dates as well as staff initials. There were no noted lapses or errors documented. Weekly side effect monitoring was documented for each youth and maintained in their IHCR. A third applicable record was not available. Five staff were interviewed and asked who provides medication to youth. Each staff indicated nurses provide medication to youth.

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

The program has a written policy and procedures to ensure medication administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a registered nurse (RN). The program has four full time RN's, one serves as the Health Services Administrator and one is a per diem RN. Each nurse has a current valid State of Florida license. At the time of the annual compliance review, the program had no healthcare position vacancies. A review of five youth individual healthcare records found four youth were prescribed

medication. No youth required parenteral medication during the annual compliance review week. The program has established procedures for registered nursing staff to administer parenteral medication. Reviewed Medication Administration Records (MARs) for each applicable youth found medication was administered as prescribed. Two medication passes were observed during the annual compliance review week. In each instance, the medication was administered in accordance with the five rights of medication administration. Youth approached the nurse one at a time, identified themselves and verbalized the name of their prescribed medication and each related side effect. None of eight observed youth indicated they were experiencing side effects at the time of medication administration. There were no refusals of medication during observed medication passes. The medication cart was stationed against the wall adjacent to the door of the clinic. Direct care staff accompanying youth stood beside the youth on the outside of the clinic door during medication administration. Each medication was crushed, mixed with applesauce and administered by the nurse to the youth using a wooden tongue depressor. Each youth drank water provided by the RN after medication ingestion. The RN thoroughly checked each youth's mouth using a cotton swab to ensure the medication was swallowed and instructed the youth to cough. Medication was not pre-poured prior to administration. With the exception of one chewable medication, all other medication was crushed into unsweetened applesauce. The medical clinic and working space was observed to be clean and organized. The observed process was structured and interactive. One mid-day medication pass for one youth was observed. The RN had prepared the crushed medication in applesauce, and subsequently obtained the youth's vitals before administering the medication. While taking the youth's vitals, the RN left the medication cup unsupervised on top of the medication cart. Five youth were interviewed and asked who gives medication and what the process is. Three youth reported they do not take medication. Two youth taking medication reported medication is administered by the nurse. One youth reported they get their medication during morning medication pass and one youth reported going to medical after lunch time for medication administration. Five staff were interviewed and asked who provides medication to youth. Each staff indicated nurses provide medication to youth.

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

The program has a written policy and procedures for youth self-administration of medication of oral medications, topical, or inhaled prescribed medications assisted by non-licensed trained staff. Reviewed documentation verified the program has four non-licensed staff trained to assist youth with self-administration of medication to include two supervisory staff, the Assistant Facility Administrator (AFA) and unit manager. Trained staff may assist youth with the self-administration of medication when nursing staff are not on-site. Non-healthcare staff are required to consult with the Health Services Administrator prior to over-the-counter (OTC) medication being provided to youth. Interview with nursing staff and the Health Services Administrator and review of documentation verified non-licensed staff have not provided OTC medication to current youth. Five youth were interviewed and asked who gives medication and what the process is. Three youth reported they do not take medication. Two youth taking medication reported medication is administered by the nurse. One youth reported they get their medication during morning medication pass and one youth reported going to medical after lunch

time for medication administration. Five staff were interviewed and asked who provides medication to youth. Each staff indicated nurses provide medication to youth.

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

The program has a written policy and procedures to ensure psychotropic medication is provided pursuant to a physician's order and is monitored to ensure the youth's safety, as required by the Department. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist who maintains professional liability insurance which expires January 25, 2020. Reviewed psychiatrist services delivered and sign-in sheet verified the psychiatrist is on-site weekly. All youth are referred to the psychiatrist for an initial psychiatric evaluation within fourteen days of admission. The Department's Clinical Psychotropic Progress Note (CCPN-HS006) is used by the psychiatrist to document the evaluation. The psychiatric evaluation documents diagnosis, target symptoms of each medication, evaluation and description of the effect of medication on target symptoms. Monthly follow-up is conducted with youth. A review of five youth individual healthcare records found one youth was prescribed psychotropic medication upon admission. One additional applicable youth record was selected for review. Each youth continued to receive psychotropic medications until the initial diagnostic interview was conducted. Each interview was conducted within fourteen days. A third applicable youth record was not available for youth entering the program with prescribed medication. After admission an in-depth evaluation was completed within thirty days for youth prescribed psychotropic medication at the time of admission or within thirty days of the initial prescription of psychotropic medication after admission.

4.34 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The facility shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines.	

The program has a written policy and procedures to ensure there is an approved plan for infection control. The infection control plan is combined with the exposure control plan and was approved by corporate on July 10, 2017, was reviewed by the Designated Health Authority (DHA) on July 9, 2018 and was signed by the newly hired Facility Administrator (FA) on September 10, 2018. The plan is developed in compliance with requirements outlined in the Occupational Safety and Health Administration (OSHA) federal regulations and guidelines. The Infection Control Plan addresses infectious diseases, contagious illnesses, tuberculosis, human immunodeficiency virus (HIV), Hepatitis A, B and C, outbreaks of pediculosis and scabies, foodborne illnesses, bio-terrorist agents, chemical exposures, and methicillin-resistant staphylococcus aureus (MRSA). Staff are trained to follow universal precautions in the workplace and are offered the opportunity to receive hepatitis B immunizations. Personal protective equipment is available for staff. There were no instances in which the local county health department, Center for Disease Control and Prevention (CDC) or the Department's Central Communications Center (CCC) should have been notified of an infectious disease.

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

The program has a comprehensive infection control plan including staff training during the pre-service phase and in-service annually. A review of five youth individual healthcare records found each youth received training on infection control, handwashing techniques, universal precautions, prevention of transmission of communicable diseases, vaccinations and the Center for Disease Control and Prevention (CDC) guidelines for infection control.

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

The program has a written exposure control plan which is in conformance with the Occupational Safety and Health Administration (OSHA) standards (29 CFR 1910), with maintenance and documentation of the plan, pursuant to the requirements of the Department. The plan addresses risk management, methods of compliance, engineering and work-place controls and training requirements. The plan is combined with the program's exposure control plan. The program reports there were no incidents involving a contagious disease warranting the quarantining or hospitalization of at least ten percent of the total population of youth or staff. Interview with the Facility Administrator (FA) indicated the exposure control plan is maintained in the medical office and is reviewed annually.

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

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

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

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

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures for youth supervision, indicating staff are to maintain active supervision of youth at all times, which includes interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing behavior of youth, and consistently applying the program's behavior management system (BMS). Youth and staff observations were conducted by the annual compliance review team throughout the review week. The program conducts youth movement throughout the day for various activities, as outlined on the daily activity schedule. Youth were observed on various days during school, lunch, and recreational time during the week of the annual compliance review. All staff were positioned properly during lunch and recreational time. Randomly selected staff were able to provide the number of youth being supervised. Staff were able to explain the procedures when a count cannot be reconciled. According to the program's contract and policy, the program must maintain a minimum staff-to-youth ratio of one staff for every six youth while the youth are awake, one-to-six (1:6) while the youth sleep, and if appropriate, one-to-five (1:5) for applicable off-site activities. On the first day of the annual compliance review, one youth from Alpha dorm was observed during the tour using the restroom in the school building unsupervised. The Facility Administrator (FA) reported during an informal interview staff are positioned to observe the classroom and restroom at the same time. However, staff were not positioned properly to monitor the youth in the restroom. A review of randomly selected video recordings of the program's ten-minute checks from six different dates was conducted during the annual compliance review. While reviewing random ten-minute room check video footage between February 1- 25, 2019 for various times during B and C shift the program was not in compliance with the ratio of 1:6. Additionally, one youth from Alpha dorm was observed on day two of the annual compliance review leaving the restroom unsupervised in the school building returning back to group. An observation made on day four found twenty-two youth being supervised by three youth care workers. The program was out of compliance of the 1:6 staff to youth ratio.

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

The program has a written policy and procedures which outlines their behavioral management system (BMS). The program has a clearly written BMS which is a multi-level system. The BMS fosters accountability for behavior compliance with program rules and expectations. The BMS includes recognition of accomplishments and positive behaviors at a four-to-one, rewards-to-consequences ratio. Youth are awarded points daily based on each youth's positive

performance, behavior, and participation with program activities. The BMS is clearly written, was observed to be posted in the dorms, and is defined in the youth resident handbook. Each youth receives a copy of the resident handbook upon their admission to the program. Incentives are posted monthly on a calendar located in each dorm. The BMS includes a process for staff to explain to youth the reasoning for any sanctions imposed upon, and youth the opportunity to explain their behavior. The program's current BMS has not been changed since the previous annual compliance review. Seven pre-service and seven in-service training records were reviewed. Six of seven pre-service records included supporting documentation of all staff completing BMS training. One pre-service training record did not have supporting documentation to confirm BMS training was completed. Seven reviewed in-service records included supporting documentation of all staff completing BMS training. During the annual compliance review, the program had four volunteers. The program's contract requires teachers and volunteers to be trained in the BMS. There was no documentation to support teachers or volunteers were trained in the BMS. However, staff who are trained in the BMS are always present during school hours and when volunteers are on-site. An interview with the Facility Administrator (FA) found implementation of the BMS is monitored to ensure it is fairly administered by way of communicating during treatment team meetings, and special treatment meetings. The program uses the positive performance system which is a three-point system which provide incentives daily, weekly, and monthly. The FA also indicated youth rewards are monitored through the positive performance system daily. Five interviewed staff were familiar with and able to summarize the program's BMS and indicated things cannot be taken away from a youth as a consequence. The staff were able to give various examples of rewards and incentives for youth, which included snacks, and pizza parties. Five interviewed youth were able to explain consequences used in the program. Three youth reported level freeze and two youth reported a special treatment team meeting would be held. Each interviewed youth was able explain the difference between each level, how to move from one level to the next, and explain the rewards used in the program.

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

The program has a written policy and procedures regarding the behavior management system (BMS), which requires staff to explain the justification of sanctions imposed, with allowing the youth an opportunity to explain their behavior. A review of the program's policy incorporating the BMS and the provider's contractual agreement found the BMS has not changed, nor is it in the process of changing, since the last annual compliance review. All required parties were involved in the development, implementation, and on-going maintenance of the BMS. Staff and youth discuss the youth's behavioral impact on others, reasonable reparations for harm caused to others, and alternative acceptable behavior. Any violation which may result in privilege suspension, program restrictions, or a level drop will be reviewed by each youth's case manager and treatment team prior to the assignment of the consequence. The Facility Administrator (FA)

reported during an interview, consequences are monitored through treatment team meetings, which involve the juvenile probation officer (JPO), youth, parent/guardian, case manager, an education representative and therapist. The program's current BMS does not include increased length of stay, denial of a youths' basic rights, promotion of group punishment, punishment of youth by other youth, or room restriction. Five staff were interviewed regarding receiving feedback from supervisors about the implantation of the BMS. One staff reported feedback is provided during shift meetings. One staff reported supervisors do not provide feedback. Two staff reported youth are advised during special treatment team meetings while another staff responded staff inform youth as soon as points are taken away. Five youth were interviewed and stated youth are not allowed to punish other youth. Four youth indicated staff are consistent in the use of rewards by providing daily incentives. One youth stated he does not receive incentives. Three youth rated the BMS as good and two rated the BMS as fair.

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

The program has a written policy and procedures in place to conduct and document ten-minute room checks. The program has a total of thirty-two cameras on-site. All cameras were operational during the time of the annual compliance review. An informal interview with the unit manager confirmed the program stores video recordings for up to thirty-days. The Alpha dormitory is an open bay building; therefore, youth do not have individual rooms. Staff are to initial on the room check sheets to verify who competed the check. If a youth is not in the room/area at the time of a room check, the row is marked with an "X" in the box for the time of the room check to indicate the room/area is vacant. The dorm has two operable closed-circuit television cameras on each side of the dorm to record all activity. A random review of ten-minute room check sheets and video footage for February 1- 25, 2019 for various times were reviewed for B and C shift. On February 1, 2019, it was documented on the room check sheets a ten-minute check was completed at 10:16 p.m. and 10:41 p.m. However, video footage revealed the ten-minute check was not completed. On February 3, 2019 it was documented on the room check sheets a ten-minute check was completed at 1:10 a.m. and 1:47 a.m. However, video footage reflected the ten-minute check was not completed. On February 4, 2019, it was documented on the room check sheets a ten-minute check was completed at 3:08 a.m. However, video footage revealed the ten-minute check was not completed. On February 25, 2019 it was documented on the room check sheets a ten-minute check was completed at 4:18 a.m. However, video footage revealed the ten-minute check was not completed. A review of the ten-minute check sheets in comparison with video footage also found ten-minute checks were not documented in real time. A review of the ten-minute check sheets found staff would document a time rather than an "X" when a youth was not in his assigned area. Youth were observed cleaning up or walking around on B and C shift when checks were being conducted. It was also observed while reviewing video footage the program was not in compliance with the required staffing ratio of one staff for every six youth during various times on B and C shift. This information was discussed with the program's regional compliance manager and a report to the Department's Central Communications Center (CCC) was made to report the incident. Five staff were interviewed and stated room checks are conducted every ten-minutes when youth are placed in their rooms 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 practicable after order has been restored.* *The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.*	

The program has a written policy and procedures which includes tracking daily census information. Youth are accounted for at all times by physical counts and random head counts, when requested by master control. According to the program's policy, they are to conduct a minimum of six formal counts throughout the day at designated times and on-going informal counts within each twenty-four-hour period. A review of the program's logbook validated headcounts are being conducted, as required. All formal counts in the logbook included the time of the count, location, and number of youth accounted. A review of the logbook further reflected consistent documentation of daily youth head counts, youth movements, admissions, releases, and youth temporarily away from the program. The program's daily census is reviewed each morning during the program's morning management meeting which includes administrative staff and department heads. The program also maintains an updated grease board within master control which reflects the program's current census. Observations made during the annual compliance review week found counts were being conducted and reported to master control on a consistent basis. All formal and emergency counts are reported to master control and are documented in the facility logbook. The program has a process outlined in their facility operating procedure which references staff conducting emergency counts should a discrepancy occur. Five interviewed staff indicated emergency counts are conducted when a discrepancy in youth counts occur.

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

The program has a written policy and procedures regarding logbooks which indicates the program shall maintain and properly document a logbook system to record routine and emergency situations involving youth and all other critical aspects of the program. The program utilizes a single logbook maintained by master control and generates shift reports for staff to review. A review of the previous six months of logbooks was conducted. The logbooks were observed bound with numbered pages. No pages appeared to be missing or falling out. All entries were made in ink, with no white-out areas or erasures. Errors were struck through with a

single line. Entries included the date and time of the event, name of staff and youth, a brief description, and a signature of the staff making the entry. Incoming staff must sign and date shift reports for the previous shift indicating the information was reviewed or verbally briefed with staff. The program does not maintain logbooks within the youth living areas. The logbooks had color-coded highlights to capture significant events. Reviewed logbook entries included documentation of calls/reports to the Department's Central Communication Center (CCC), as required.

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

The program has a written policy and procedures regarding maintaining and controlling keys utilized within the facility. The program's key control system included key assignment restrictions and usage, the inventory and tracking of keys, secure storage of keys when not in use, procedures addressing missing or lost keys, and reporting requirements and replacement of damaged keys. Each staff who is assigned permanent keys must sign a permanent key assignment acknowledgment form. Facility keys are separated as restricted and active keys are kept in master control in a locked key box. Medical and mental health staff have a separate key box located in master control. The facility also keeps track of permanently issued keys. Staff gain access to the facility by way of master control. All youth care workers are issued active keys. Upon starting their shift, staff submit their personal keys and receive an assigned facility key for their shift through master control. All staff return keys to master control at the end of their shift. The master control operator documents the name and the time of the staff receiving/returning the key. Visitors submit their keys to the master control operator who then provides the visitor with a numbered chit which will identify their key upon their exit. A random check of three staff found no personal keys were maintained in their possession. An informal interview was conducted with master control operator. The master control operator indicated if keys are lost, all movement in the facility is stopped, the Facility Administrator (FA) is contacted, and a search for the missing keys is conducted. In the event the keys cannot be located, a report is made to the Department's Central Communications Center (CCC) and the program will take proper procedures to replace the key. Damaged keys are turned over to master control and the physical plant manager is notified to have the key replaced. A review of CCC for the past six months indicated there was no report of any keys being missing. Five staff were interviewed and were able to explain the program's key control process including how keys are assigned, the process for missing or lost keys, damaged keys, and restricted keys.

5.08 Contraband Procedure	Satisfactory Compliance

The program shall develop and implement a system to prevent the introduction of contraband into the program.

A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.

The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the 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.

The program has a written policy and procedures which outlines a list of items considered to be unauthorized and illegal contraband and how it is to be disposed. The policy, along with the youth handbook, outlines provisions for searches of youth incoming and outgoing mail for contraband. The program also provides youth with a youth handbook, outlining search procedures and consequences for contraband possession. The list of items considered contraband include personal cell phones and electronic devices capable of taking pictures and/or video recordings, which are prohibited in the secure areas of the program. Five reviewed youth case management records contained a list of items considered contraband. The program's staff conducts unannounced random searches of youth's sleeping area at a minimum of weekly. These searches are documented on a program specific room search form which are maintained in a centralized binder. A review of the program's contraband binder found specific room search forms missing for various weeks out of the binder for the months of September 2018 through February 2019. However, a random review of the program's logbooks confirmed the program conducts random searches at a minimum of weekly. The Facility Administrator (FA) reported discovery of illegal contraband is reported to law enforcement.

5.09 Searches and Full Body Visual Searches	Satisfactory Compliance

The program shall perform searches to ensure no contraband is being introduced into the facility.

The program maintains a written policy and procedures for searches and full body visual searches. The program's practice is to conduct searches upon each youth's admission, departure, after visitation, before and after any off-site activity, and movement from one area of the program to another. Observations made during the annual compliance review confirmed this practice. All observed searches were performed by a staff member of the same gender. Staff were observed giving clear instructions. Searches were thorough, and youth were treated with dignity and respect to minimize stress or embarrassment. Searches were conducted in accordance with the program's policy and Protective Action Response (PAR) training. There were no newly admitted youth during annual compliance review. Five interviewed staff were able to summarize the search procedures within the program. Staff reported searches are conducted several times throughout the day. Five interviewed youth reported and confirmed

searches occurred at the program daily, and during times such as returning from off campus, after outdoor activities, when items are missing, after visitation, after meals, and after work detail.

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

The program has a written policy and procedures regarding the maintenance of vehicles for transporting youth. The program has two vehicles which are used to transport youth for off-campus activities such as court, medical, or dental appointments. . Reviewed documentation reflected each van used had an annual safety inspection and any deficiencies found were corrected. Transportation staff complete inspections on each of the vehicles weekly and before each use. Each van was observed to be equipped with a seatbelt cutter, window punch, fire extinguisher, first aid kit, and the appropriate number of seatbelts. First aid kits for the vehicles were maintained in master control and are checked out along with the vehicle keys when vans are used. A review of the first aid kit contents found all items were up-to-date and contained all required items. A check of each transport vehicle at the program found all vehicles were locked when not in use and all vehicles have a usage log and inspection sheet. Neither van permitted youth availability to exit from the rear doors while inside the van for security reasons.

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

The program has a written policy and procedures regarding the transportation of youth. Any youth being transported are supervised based on a one-to-five ratio. The program maintains a list of eligible staff to transport youth indicating who is eligible and who is ineligible. Transporters are provided a fully charged cellular telephone to communicate during emergency situations. Staff are not allowed to transport youth in their personal vehicles unless it is an emergency and approved by the Facility Administrator (FA). During the annual compliance review, there were no transports to observe, however random interviews with staff and youth verified seatbelts are used when operating the vehicles and the appropriate ratio is maintained. The program conducts driver's license checks each month for all staff. Vehicles used to transport youth were found secured. One van had a safety screen separating the front seat, or driver’s compartment, from the back seat, or rear passenger’s compartment. A staff member is required to position themselves in the back with the youth during transports. Inspections of the inside of the program vehicles also found the rear doors could not be unlocked from the inside. One interviewed staff reported a program cellular telephone is provided to communicate when transporting youth. One staff reported a two-way-radio is provided to communicate when transporting youth. All interviewed staff report they are not allowed to transport youth in their personal vehicle. On

February 27, 2019 a random check of approximately ten personal vehicles in the parking lot of the program was made during the week of the annual compliance review and found one personal vehicle unlocked.

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

The program has a written policy and procedures which outlines conducting weekly safety and security inspections. The policy addressed who is responsible for conducting the audits, procedures to implement corrective actions for deficiencies, and an internal system to verify deficiencies are corrected. The program maintains completed weekly safety and security audit forms in marked security binders. The weekly security audits and safety inspections address radios, communication devices camera surveillance, digital video recorder (DVR), perimeter, and fencing to ensure all areas are secure. Reviewed documentation during the annual compliance review, found evidence the program completed the inspections weekly, as required, with no exceptions. The Assistant Facility Administrator (AFA) is responsible for conducting the weekly security audits and safety inspections. Supervisors also conduct perimeter checks on each shift and document these checks in the facility logbook. Any deficiencies are addressed on the form and a work order is submitted to the appropriate staff for corrections. Deficiencies are also discussed during the morning managers meeting. An interview with the Facility Administrator (FA) indicated weekly safety and security checks are conducted to identify and track safety and security deficiencies.

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

The program has a written policy and procedures to address tool inventory and management, and youth handling and supervision when utilizing tools. The physical plant manager is appointed as the program's tool control manager. An observation of the tool storage area found all areas were secured and inaccessible to youth. Tools are organized on a shadow board accompanied by a picture of the tool. The tool inventory list consists of class A and B tools. Tools are kept in a locked cabinet and are inventoried daily by the physical plant manager. In addition, any tools used are signed in and out on a perpetual inventory form. Observations of this documentation was found to confirm this practice. A review of seven staff training records confirmed staff are trained in the safe use of tools. Kitchen knives and utensils are also inventoried twice daily. An interview with the dietary manager revealed youth are prohibited from being in the kitchen area. Kitchen knives were observed stored in a clear locked cabinet and hanging in their respective location. The inventory sheets were reviewed. All items were accounted for based on the shadow-board system observed. Five youth were interviewed concerning their usage of tools. Three youth responded they were not allowed to use tools. One youth responded they have used mops and brooms. One youth reported using a paint brush.

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

The program has a written policy and procedures to address tool inventory and management, and youth handling and supervision when utilizing tools. The policy indicates youth are only allowed to use tools under the direct supervision of staff. A designated storage room contains three brooms, three mops, two mop buckets, three dust pans, and three toilet brushes. A documented risk assessment is completed for youth upon their admission to the program, and monthly thereafter. The risk assessment examines the youth's time spent in the program, any aggressive behavior exhibited, history of escapes, and progress or lack of progress prior to recommending the youth for usage of tools. A review of staff training records and youth case management records indicated staff and youth are trained in the use of class B tools. Observations made reflected all tools were securely stored when not in use. An inspection of the storage area of class B tools found the inventory log matched the number of items on the list. Reviewed documentation coupled with observations made during the week of the annual compliance review confirmed the program provides the appropriate minimum staff-to-youth ratios during activities involving tools. Upon completing the work detail, staff conducts a search of each youth once the class B tools are put away. Three staff reported youth utilize cleaning items such as mops and brooms. One staff reported youth do not utilize tools.

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

The program has a written policy and procedures to address any tools brought on-site by outside contractors. The policy indicates the program will closely monitor the use of tools brought into the facility or on facility grounds. The program maintains a sign-in log for contractors who provide repair services. The vendor is required to review a checklist of expectations and sign indicating they had been advised and agree to the requirements of entering the facility. A review of the program's repair invoices confirmed outside vendors signed the visitor's log on the date consistent with the invoice for the services provided. The program's practice is to conduct an inventory of tools entering the facility and conduct an inventory prior to the outside contractor leaving the program. However, reviewed documentation of the signed contractor's form did not validate this practice. A review of the contractor's form for the past six months did not reflect maintenance staff were consistently documenting the tools contractors were bringing on-site. Additionally, maintenance staff were not conducting an inventory check of the tools upon the contractor's departure. This information was brought to the attention of the regional compliance manager during the annual compliance review. During the annual compliance review, administration staff provided documentation to support disciplinary action was taken prior to the annual compliance review. During, an interview the physical plant manager indicated youth are not allowed in the vicinity of the work area where the contractors are working.

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

The program has a Continuity of Operations Plan (COOP) which outlines fire, safety, and evacuation emergency drills shall be conducted monthly at random times and under varied conditions. Drills are documented on a program specific drill form. The drill forms capture the nature of the drill, date, time, signature of participants, along with a brief scenario to capture the results of the drill, and recommendations. Each drill form is signed by staff who participated in the drill, as well as, the facilitator. Observations made during the annual compliance review found egress plans posted throughout the program. A review of these drills for the previous six months found evidence the program conducts fire and various COOP drills monthly with staff on duty. However, the drills did not indicate the shift the drill was conducted on. A review of each drills narrative provided further information, which helped determine the shift the drill was conducted on. The Facility Administrator (FA) reported drills are conducted monthly and quarterly. Five interviewed staff reported they have participated COOP drills. Four staff reported they have participated in fire drills, one replied and escape drill, while another staff reported mental health, medical, and COOP drills. Four out of five interviewed youth all reported they have been informed as to what to do in the event of a fire. One youth stated not being informed on what to do during a fire. Three youth indicated fire drills are conducted monthly. One youth stated fire drills are conducted weekly, and one youth stated fire drills are not conducted at the program.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature.	

The program has a written and detailed Continuity of Operations Plan (COOP) which identifies a coordinated disaster plan. The recent version of the COOP was signed and approved by the Department on May 18, 2018. The COOP included all of the required elements in 63E-7.013 (20), Florida Administrative Code. The regional compliance manager reported the COOP is located in the offices of the facility administrator, medical office, and master control located in the administration building. An interview with the Facility Administrator (FA) indicated a copy of the COOP is maintained in master control where all staff have access.

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

The program has a written policy and procedures for the storage and inventory of flammable, poisonous, and toxic materials. All flammable, poisonous, and toxic materials are located outside the perimeter fencing in a locked storage shed. Observation of the storage area indicated it is clearly marked hazardous chemicals and securely locked. Items were neatly stored on metal shelving and numbered according to the Safety Data Sheets (SDS). Flammable items are stored in a metal cabinet clearly marked as flammable items. According to the

physical plant manager, gasoline is not stored at the program. Gasoline is obtained at the local gasoline station and only the amount needed to complete the maintenance project is purchased. Youth are strictly prohibited from the maintenance area where toxic items and chemicals are stored. The program maintains a list of the positions, titles, and functions of those staff authorized to handle these items. A SDS binder is maintained with a number corresponding to the SDS for each item. A perpetual chemical inventory list is maintained and checked daily. A running daily log is maintained to track toxic items when in use by authorized staff. A review of the program's chemical daily usage log included the name of the chemical being used, the purpose for usage, the amount being used, data chemical is use and signature of the staff using the chemical.

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 has a written policy and procedures prohibiting youth from handling flammable, poisonous, and toxic materials. The program maintains strict control of all flammable, poisonous, and toxic materials. Toxic items are stored in a locked shed located outside of the secure area of the program. The shed is secured with a padlock on the outside door and the toxic items are also locked on the inside of the shed. Youth do not use, handle, or clean-up dangerous or hazardous chemicals or any person's bio-hazardous material, bodily fluids, or human waste. Staff are to handle any chemicals and the youth may only wipe down surfaces after staff administer the chemical(s). The youth are restricted from the areas where hazardous items are stored. When needed, authorize staff signs out the chemical. A review of the chemical sign-out log validated this practice. Five interviewed youth stated they do not handle any flammable, poisonous, toxic, or caustic materials. One youth reported assisting with paint.

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

The program has a written policy and procedures regarding the proper disposal of all flammable, toxic, caustic, poisonous items. These types of hazardous materials are to be disposed according to Occupational Safety and Health Administration (OSHA) requirements. All unused hazardous materials are kept in the locked storage shed. Used kitchen grease is stored in large container outside the kitchen area and is disposed of quarterly by AAA Above All Septic and Drain. The Facility Administrator (FA) reported during an interview toxic, caustic, and poisonous items are disposed of as recommended by the manufacture. In the event a chemical spill occurs, staff are required to report the spill to master control immediately and the shift supervisor. The youth and staff will then evacuate the affected area. The FA will contact outside assistance to clean up the chemical spill if necessary. Staff and youth are not allowed to return to the affected area until it has been deemed safe by a qualified professional. The unit manager reported there has not been any chemical spills since the last annual compliance review.

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

The program has a written policy and procedures which outlines recreational and leisure activities. The program contract requires the program to employ a certified recreational therapist. The educational requirements listed state the candidate should preferably have a bachelor's degree of science in Recreation and Sports Management with a track in Recreational Therapy. However, the clinical director who does not have the required credentials has been providing recreational services due to the recreational therapist resigning on December 28, 2018. The program has recruited for the position by posting on-line hiring events on January 4, 2019 and February 15, 2019.The program provided documentation of a potential candidate for the recreational therapist position who will begin March 18, 2019. The program has one full-time recreational therapist position who is required to work with the youth by conducting recreation therapy assessments and developing wellness plans. The recreational therapist is a direct report to the DMHCA. At the time of the annual compliance review the recreational therapist position was vacant. The program reported the position has been vacant since December 28, 2018. The program has identified an individual from the Miami Youth Academy to fill this position; however, the program did not have a start date at the time of the annual compliance review. The program maintains a daily schedule of indoor and outdoor activities to expose the youth to different recreational choices and activities, which vary on a daily basis. A review of the program's activity schedule and comparison with logbooks verified this practice. During the annual compliance review, outdoor activities were observed on three consecutive days. An observation of the daily schedule found kickball is scheduled for Tuesdays, basketball on Wednesdays, and work-out on Thursdays. The program was in compliance on Wednesday and Thursday according to the daily schedule. Additionally, youth were observed playing kickball during recreational time without proper footwear, which can result to physical injury. Five interviewed staff indicated youth are provided with at least one hour of sporting activities each day. Five youth were interviewed and indicated they are allowed to have outdoor recreation to include football, basketball, kickball, and soccer.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a detailed policy and procedures which thoroughly outlines the visitation process at the program. The visitation schedule is provided to the youth as part of their orientation packet and is provided to the parent/guardian as part of the intake process. Each youth receives a copy of the resident handbook upon intake which clearly explains all visitation and correspondence opportunities to the youth. Youth are also informed of visitation at the time of their orientation to the program. The program maintains a list of authorized visitors and correspondence in each youth's case management record. Reviewed documentation for five youth supported youth are afforded the opportunity for visitation once a week each Sunday. Visitation is held in the multi-purpose room on Sundays from 2:00 p.m. to 4:00 p.m. Alternative visitation arrangements are considered for parents/guardians who are unable to participate for Sunday visitation on a case-by-case basis. Youth are also provided weekly telephone calls, writing material and a self-addressed stamped envelopes to communicate with approved family

members. Youth are allowed to have unimpeded access with the courts, attorneys, the juvenile probation officer (JPO), and/or the Department of Children and Families (DCF) case worker. Observations found the visitation schedule posted on the wall of the administration office where all visitors report. Five interviewed youth revealed they have many opportunities to communicate with their family through visitation events, mail, and telephone.

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

The program's policy, procedure and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program's policy, procedure and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program's policy, procedure and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

Program Name: Dade Youth Academy
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: Miami-Dade County / Circuit 11
Review Date(s): February 26 - March 1, 2019

MQI Program Code: 1418
Contract Number: 10080
Number of Beds: 24
Lead Reviewer Code: 149

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.17 Advisory Board	1.12 Restorative Justice Awareness for Youth
3.13 Suicide Prevention Training*	5.04 Ten-Minute Checks*
5.01 Youth Supervision	
5.15 Outside Contractors	
5.21 Recreation and Leisure Activities	