STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Daytona Juvenile Residential Facility (JRF)
TrueCore Behavioral Solutions, LLC
(Contract Provider)
1386 Indian Lake Road
Daytona Beach, Florida 32124

Review Date(s): October 22-25, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Lea Herring, Office of Program Accountability, Lead Reviewer (Standard 1)
Stephanie Burns, DJJ Probation, Circuit 5, Senior Juvenile Probation Officer (Standard 2)
Jill Foy, Office of Program Accountability, Regional Monitor (Standard 4)
Ryna Jefferson, Home Builders Institute, Circuit 4, Director of Program Accountability (Interviews)
Jillian Lewandowski, DJJ Probation, Circuit 7, Assistant Chief Probation Officer (Standard 3)
Aaron Mathews, Office of Program Accountability, Contract Management Supervisor (Standard 5)
Angel Perez, Office of Program Accountability, Operations Review Specialist (Standard 4)

Program Name: Daytona Juvenile Residential Facility
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Volusia County / Circuit 7
Review Date(s): October 22-25, 2019

MQI Program Code: 1226
Contract Number: R2107
Number of Beds: 32
Lead Reviewer Code: 127

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.26 Safety Planning Process for Youth	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Daytona Juvenile Residential Facility is a thirty-three bed program, for thirteen to eighteen year old males, located in Daytona Beach, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides sex offender treatment services. In addition, the program fosters each youth by providing group therapy such as Pathways: A Guide Workbook for Youth Beginning Treatment, Roadmap to Recovery, Footprints – Steps to a Healthy Life; Anger Mangement for Substance Abuse and Mental Health Clients, Conflict Resolution from the Inside Out, Transforming Anger to Personal Power, Social Skills Lesson and Activities for grades 7-12, Stress Management for Adolescents, 100 Interactive Activities for Mental Health/Substance Abuse Recovery, Creative Therapy, and Young Men's. Treatment services are provided in group, individual, and family counseling, interventions, and curriculums. Currently the recreational therapist position is vacant. The program's administration is comprised of an acting facility administrator who also serves as the provider's regional manager, the assistant facility administrator (AFA), the administrative assistant, physical plant manager. The AFA oversees four shift supervisors who oversee seventeen youth care workers I and seven youth care workers II, as well as the AFA oversees one vocational instructor. Case management services include one case manager and one transitional service manager. In addition to the director of clinical services who serves as the designated mental health authority (DMHCA) supervises three therapist and the recreational therapist which is currently vacant. The health services coordinator oversees one license practical nurse (LPN). The program also includes the designated health authority (DHA) and the psychiatrist who are doctors contractually required to make monthly visits to the program to see youth based on their needs. The program provides food service through a contracted food service provider. Medical services are offered seven days a week and are provided by one medical doctor who serves as the DHA and one full time registered nurse (RN). Educational services are provided by the Volusia County School Board. The layout of the program includes two primary buildings including an administrative/education portable and a brick building which houses the youth dorms, medical office, cafeteria, multi-purpose room, and staff offices. The program has twenty-four operable cameras capable of storing up to thirty days of footage. At the time of the annual compliance review, the program had six vacant positions which include the recreational therapist, a part-time RN, and four direct care staff.

Standard 1: Management Accountability

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

Background screening is to be completed for staff, volunteers, contractors, and interns prior to their date of hire or services being provided. Since the last annual compliance review, the program hired twenty-five staff and one volunteer. A review of the Department's Background Screening Unit/(BSU) Clearinghouse screenings and personnel records were reviewed. All twenty-five staff received background screenings with nineteen staff screenings returned prior to their date of hire. The six staff receiving background screening after the hire date ranged from three days after date of hire to twenty-one days. An interview with the program's administrative assistant and the review of staff training confirmed staff do not have contact with youth until four weeks after their hire date. The one applicable volunteer reviewed did not receive a background screening, but volunteers are reported to be on-site for two hours a month and under constant supervision of program staff while with the youth. A pre-employment assessment tool is completed with a passing score for all hired staff. Administrative staff confirmed staff are added to the program's Clearinghouse employment roster as they are hired. An Annual Affidavit of Compliance with Level 2 Screening Standards was submitted by the program to the Department's BSU on December 11, 2018, meeting the annual requirement. Education staff at the program are funded through the Volusia County School Board who also submitted an Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU on December 6, 2018.

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

The program has a written policy and procedures which addresses background screenings and re-screenings of program staff. The program's policy states all staff will receive a background rescreening every five years from the date of their initial employment. None of the program staff, volunteers, or contracted employees were applicable for a five-year rescreening from the staff rosters provided during the annual compliance review.

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

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

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

The program has a written policy and procedures addressing abuse and neglect reporting to include the steps to report the alleged abuse or neglect of a youth at the program which include a zero tolerance policy regarding any abuse by staff who are mandatory reporters.

The Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers were observed to be posted throughout the facility. Staff are required to sign a code of conduct during the staff employment process. Ten staff records were reviewed and contained the staff member's documented signature on the staff code of conduct, confirming this practice. The program had two incidents of abuse with allegations against staff for improper conduct/computer misuse, violation of policy/rule, and an improper/excessive use of force. The first incident was reported to the CCC and to the Florida Abuse Hotline. The Department of Children and Families (DCF) investigate all reports to the Florida Abuse Hotline and investigated the allegations of abuse, in which the investigation was closed with no indicators, inconclusive findings, and unsubstantiated findings. The program conducted an internal investigation and found three substantiated findings for two staff with corrective action. One staff admitted to improper conduct/computer misuse which was substantiated and the other staff received a substantiated findings for improper use of force and violation of policy/rule. Two staff resigned and the third staff was given an oral reprimand, but resigned two months later. All three staff are ineligible for rehire. The second incident occurred in the same month of the annual compliance review and the program's review was in progress with pending results. The second incident was reported to the CCC for a medical incident and a complaint against staff for excessive force. The youth received injuries during a Protective Action Response (PAR) and was transported to the area medical center. The management review report revealed DCF involvement as an open investigation but does not indicate the youth requested to call abuse as a result of the PAR. The program provided documentation of completing the TRACE self-assessment in April of 2019.

Five youth were interviewed and reported they feel safe at the program. Four youth reported they have not been denied from reporting abuse to the Florida Abuse Hotline or the CCC. One youth reported, one time he wanted to call but said the program stated it was not abuse. The youth explained the room and toilet were dirty with things all around when he first arrived at the program. All five youth answered in the affirmative when questioned if staff are respectful when speaking with the youth. One youth further explained it was more like "50/50" and some staff are nonchalant, will not respect you, and do not talk in a calm manner. Specifically, youth were questioned if they have heard the use of profanity by staff. Three youth stated never, one youth reported occasionally, and one youth stated often. Five staff members were interviewed and two reported the supervisor needs to be notified when a youth request to contact the Florida Abuse Hotline. Three staff stated youth and staff are allowed to call the Florida Abuse Hotline. All five interviewed staff reported they had not observed a co-worker tell a youth they could not contact the Florida Abuse Hotline. Four of the five staff members reported they have not observed a co-worker use profanity when speaking with youth, using threats, intimation, or humiliation when interacting with youth. One staff member reported they have observed a co-worker use profanity several years ago when they first started working at the program. An interview with the acting facility administrator (FA) stated all allegations of abuse are called into the Florida Abuse Hotline and CCC immediately or within two hours of the incident, with unimpeded access to call. The FA reported staff are aware of abuse reporting from pre-service and in-service training as well as abuse postings throughout the facility. The FA reported the staff code of conduct consists of conduct violations against program rules and policies. The code of conduct also includes types of associated consequences and response matrix such as coaching, oral and written warnings, suspension, and termination. If there are allegations of abuse towards staff, the incident is investigated. The FA is to determine if the alleged staff is to be removed from youth contact until the investigation is complete.

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.	

Review of the Department's Central Communications Center (CCC) incidents revealed six reports where allegations made against staff for improper actions which required a program response. Documentation of the program's management review reports reflected management took immediate action to address each applicable allegation. The first incident involved an internal investigation where three actions were substantiated by the program for two of the three staff implicated. One of the two staff resigned at the time and the other staff received an oral reprimand. The second management review report involved a staff hired before the background screening which was substantiated and a Corrective Action Plan (CAP) was put in place and the deficiency was corrected. The third incident review was of a Protective Action Response (PAR) between youth and staff which resulted in an injury to the youth. The staff was being reviewed for excessive use of force. This management review report was still open during the annual compliance review with pending results. The forth incident was a medical incident and complaint against staff for violation of policy/rule which resulted in the staff receiving a written reprimand. The fifth incident was a violation of policy/rule which was substantiated and resulted in the staff being terminated. The sixth incident was of a staff being arrested for a disqualifying offense which resulted in the staff being terminated.

An interview with the facility administrator (FA) includes the staff associated consequences and response matrix for allegations of staff conduct violations. Responses include staff coaching, oral and written warnings, suspension, and termination of employment. If there are allegations of abuse towards staff, the incident is investigated. The FA is to determine if the alleged staff is to be removed from youth contact until the investigation is complete. The FA reported one staff receiving disciplinary actions due to allegations of abuse, since the last annual compliance review.

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

In the past six months, the program had a total of eleven incidents reported to the Department's Central Communications Center (CCC). A total of six incidents reported to the CCC were reviewed. Each incident was reported to the CCC within two hours of the incident or within two hours of the individual becoming aware of the incident. Four incidents involved a complaint against staff, four included medical incident, and one incident included youth behavior. Two of the four applicable CCC reports which took place inside the facility and required the program to call, were documented in the facility logbook. A review of the youth grievances did not reflect any additional incidents which should have been reported to the CCC. There was not an increase in reportable incidents as the last annual compliance review reported the same number of eleven CCC reports reviewed.

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.	

In the past six months, the program had three incidents involving the use of Protective Action Response (PAR). Each incident report documented the PAR report was completed by the end of the staff member's workday and including statements from all staff involved. None of the incidents documented the use of mechanical restraints. Each report documented a review by a PAR certified instructor or supervisory staff. One of the incidents indicated the PAR resulted in a minor injury to the youth which did not require the youth to be transported out to a medical facility for review nor was a call to the Department's Central Communications Center (CCC) required. A post-PAR interview was conducted with the youth in all incidents as soon as possible or within thirty minutes of the incident. All three PAR incident reports were reviewed by the facility administrator or designee within seventy-two hours. Two of the three reviewed PAR incidents included a PAR medical review. The incident with minor injuries was documented with the PAR report and the incident where the youth was transported out to a local medical facility was documented throughout the CCC and management review report. All of the PAR incidents were documented in a centralized binder organized by month. The program has an approved PAR plan which was signed by the Department and the Office of Staff Development and Training on December 11, 2018. The program's PAR rate has decreased since the last annual

compliance review. The program's PAR rate during the annual compliance review period was .39, which is below the statewide Residential PAR rate of 1.39.
An interview with the facility administrator (FA) explained PAR reports are monitored daily through the morning management meeting and entered into the provider's database. The PAR incidents are tracked and reviewed to reduce incidents in program planning.

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

Five staff training records were reviewed for pre-service and certification requirements. All five staff completed the essential pre-service training which must be completed prior to any contact with youth to include cardiopulmonary resuscitation, first aid, automated external defibrillator (AED), ethics, Prison Rape Elimination Act (PREA), human trafficking, emergency procedures, child abuse reporting, restorative justice, and ten hours of suicide prevention training to include two hours in the Department's Learning Management System (SkillPro). In addition, each staff completed the required training such as gender response, positive performance, and trauma-informed care. All five staff members completed forty-hours of Protective Action Response (PAR) training. All five pre-service staff completed over the required minimum of 120 hours of pre-service training to be completed for certification. The program provided documentation to confirm the training instructors are qualified to deliver training provided for all staff certifications. The program submitted a list of pre-service training to the Office of Staff Development and Training to include course names, descriptions, objectives, and training hours on March 13, 2019 and approved by the Department on April 12, 2019. All training was documented in the Department's Learning Management System (Skill Pro).

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

Five staff members were applicable for review of in-service training. Each staff member completed the twenty four hours of in-service training to include cardiopulmonary resuscitation, first aid, automated external defibrillator (AED), ethics, suicide prevention, and an eight-hour Protective Action Response (PAR) update. Each staff completed Prison Rape Elimination Act (PREA), trauma-informed care, human trafficking for direct care staff, and stress management. Three of the staff records reviewed were for supervisors. Each supervisor completed more than the required eight hours of supervisory training with a forty-hour curriculum of On the Job Training (OJT) required when staff are promoted to a supervisor. Each supervisor received training in management, leadership, employee relations, communication skills, and fiscal training. All training was documented in the Department's Learning Management System (Skill Pro). The program maintains an annual in-service training calendar, the list of in-service trainings were submitted to the Office of Staff Development and Training to include course names, descriptions, objectives, and training hours. The in-service training plan was submitted to the Department on March 13, 2019 and the Office of Staff Development and Training approved the plan on April 12, 2019.

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

The program has a written policy and procedures addressing the grievance process. The grievance procedures details the three grievance phases to include the informal phase, formal phase, and appeal phase. The policy indicated the informal phase is an attempt to resolve disputes through informal communication such as verbal discussion among staff and youth. The program also has "Speak Out" forms and grievance forms available to youth to note any informal complaints. The formal phase includes the youth complete a grievance form which can include the assistance of a third party staff to help the youth to complete. According to policy, the formal review is processed by administrative staff such as the facility administrator or assistance facility administrator to be completed within seventy-two hours including a response back to the youth. Five youth grievances completed within the last six months were reviewed. Each grievance documented the nature of the grievance, the date the grievance was submitted by the youth, the date of the response by staff, and a youth signature acknowledging the result. Of the five grievances reviewed, the program responded the next day the grievance was submitted in four records. One record revealed the grievance was responded to the same day. All five grievances included the youth's signature of the grievance result. None of the five grievances reviewed went to an appeal phase. The program has maintained copies of the grievances for the past twelve months.

Five youth were interviewed regarding the grievance process. Each youth was able to identify once a grievance is fill out they are placed in one of the two grievance boxes located in the program. One youth stated they have never filed a grievance and two youth reported they filed a grievance out once and did not get a response. All five youth confirmed youth can request assistance in completing a grievance form. Five staff were interviewed on the grievance process. Four of the staff reported the forms are placed throughout the facility and two of the staff stated the facility administrator or designee reviews and responds to grievances. Additional staff comments from all five staff indicated a general understanding of the grievance process. An interview with the facility administrator (FA) explained the grievance process. The FA stated youth are allowed unimpeded access to the grievance forms. There is an attempt to resolve the grievance at an informal phase. If unsuccessful, the grievance form is completed and dropped in the grievance box. The grievance boxes are checked daily and answered within seventy-two hours. If the youth disagrees with the findings, there is a grievance appeal phase for the FA to review and respond within seventy-two hours, which is the final decision.

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

The delinquency interventions utilized at the program include Pathways: A Guide Workbook for Youth Beginning Treatment, Roadmap to Recovery, Footprints – Steps to a Healthy Life, Anger Management for Substance Abuse and Mental Health Clients, Conflict Resolution from the Inside Out, Transforming Anger to Personal Power, Social Skills Lesson and Activities for grades seven through twelve, Stress Management for Adolescents, 100 Interactive Activities for Mental Health/Substance Abuse Recovery, Creative Therapy, and Young Men's Work. Six staff were identified as facilitators delivering delinquency interventions. Each staff member has the required education and work experience to deliver the intervention services they are providing. Training records confirmed each staff member are trained to provide the interventions they are facilitating. The program's activity schedule reflects the program is providing structured, planned programming, and activities to include the delinquency interventions at least sixty percent of the youth's awake hours. Performance plans addressed an identified need and youth are involved in a delinquency intervention to address the identified need. Group sign-in sheets confirmed the youth's participation in the delinquency interventions. Seven youth records were reviewed for delinquency interventions participation. All seven youth records included an identified priority need in their performance plan. Two of the reviewed seven youth records completed an evidence-based delinquency intervention. The remaining five youth have not been in the program long enough to complete the assigned intervention.

Five youth were interviewed and all reported they were participating in groups. An interview with the facility administrator (FA) reported the position requirements are listed in the job description to ensure the appropriate staff are hired and providing the approved treatment services. Staff are trained on the specific curriculum prior to delivering services. The FA listed two evidence based services provided at the program which include, Thinking for a Change (T4C) a group focused on cognitive behavioral therapy. The FA explained youth are matched to staff based on the youth assessment results and type of service needed.

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

Life skills training is provided utilizing the curriculum Life Skills 225. Each week for one hour, youth attend a social skills and coping skills group which incorporates the life skills training. The youth also attend a separate group for an hour each week for conflict resolution and thinking, feeling, and behaving. The program's activity schedule reflected the groups are conducted each week. Group sign-in sheets confirmed topics address life skills such as communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking including problem-solving and decision-making. Five youth records indicate they are receiving services as outlined. Staff training records confirmed they have been trained to deliver the curriculum.

Five youth interviews were conducted and each youth was able to identify groups they participated in and new skills or behaviors they have been taught while in the groups. Each youth indicated the skills learned are practiced during group and outside of group.

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

The program conducts Impact of Crime (IOC) and Pathways groups as restorative justice awareness for youth to increase accountability for criminal actions and harm to others. Restorative justice activities are conducted and planned as designed. Sign-in sheets were reviewed to confirm services are being delivered as outlined, as well as an observation conducted of youth treatment groups by the Department's Programming and Technical Assistance Unit. Review of five training records confirmed staff are trained to conduct restorative justice awareness groups. The program has a victim wall in the case management area and the program utilizes a victim chair to represent the youth's victim as a reminder of the impact of their crime.

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

The program utilizes Young Men's Work, Teen Relationships, and The Guy Book as gender-specific programming. Young Men's Work is a program for young men, ages fourteen to nineteen, who are working together to solve problems without resorting to violence. The programming was included on the activity schedule. Young Men's Work curriculum contains twenty-six sections which includes objectives, an agenda, session, and exercises. Young Men's Work and Teen Relationships are considered the Male Healthy Relationships bundle and is conducted in an open group setting. Teen Relationships are held on Wednesday's and Young Men's Work are held on Monday's and Friday's which are provided to all youth in the program. The gender-specific programming demonstrates a program model or component addressing the needs of the targeted gender. The program designs the services on the common characteristics of the target population. An interview with the facility administrator (FA) listed Teen Relationships, Guy Book, and Health Education Groups designed for males.

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

The program has a written policy and procedures addressing the alert system. The policy addresses how alerts are identified, documented, updated, and communicated with employees. The program maintains an internal alert system which is easily accessible to program staff to ensure they are aware of any security concerns, safety risks, health-related concerns, allergies or special diets. The alert board with each youth's picture and colored pins associated with the youth's alerts is located in the staff briefing room. The various levels of alerts are represented by various colors which include sports restrictions, medical issues, gang affiliation, mental health-suicide precautions, escape risk, security risk, violent behavior, or special alert. The program's internal alert list was compared to the Department's Juvenile Justice Information System (JJIS) alerts. Review of the youth alerts in JJIS revealed the program opened and closed alerts in a timely manner by appropriate program staff. One youth did indicate a medical alert on the program's alert board which was not showing in JJIS. After investigating, the program was able to conclude the youth was released from the strenuous activity restriction and updated the alert on the program alert board. The facility logbook was reviewed which documents security alerts, mental health/suicide alerts, youth on close watch, and youth on precautionary observation. Five youth were reviewed and none were applicable for change in supervision level once admitted to the program.

Five staff were interviewed on how youth alert information is provided to staff. The first staff reported they are informed of youth alerts through the alert board in administration, the second staff stated they are briefed on what they need to look for in the youth, the third staff reported the logbook as a resource to review youth alerts and supervisors notify each shift. The forth staff stated alerts are reviewed at the beginning of each shift and the fifth staff stated alerts are in a binder in master control. An interview with the facility administrator (FA) explained admission classification forms provide security factors which could result in the youth receiving a security alert. Youth placed on an elevated supervision level due to a history of suicide concerns could result in the youth receiving a suicide alert. Any speculated or confirmed allergies result in an allergy alert and is shared with the Linton Food Service and the kitchen alert board. Any medical concerns included current or new diagnosis result in a medical alert. All youth alerts are listed on the program's internal alert board. Youth alert information entered including updates and alert closures are made in JJIS by the assigned department staff. Alerts are reviewed during shift briefings and morning 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 youth records to include an individual healthcare, case management, and mental health records for all youth residences. Five youth management records were reviewed. Each management record contained a tab with the required information to include the youth's name, Department identification number, date of birth, county of residence, and the youth's committing offense. Each individual management record contained the required sections to include legal information, demographic and chronological information, correspondence, case managementand treatment team activities, and miscellaneous. Each record was labeled "confidential" and records were observed to be secured in either a locked file cabinet or locked room not assessable to youth.

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

The program has a formal process to promote constructive input by youth to include monthly youth committee meetings, youth advisory board, youth surveys, and "Speak Out" forms available to youth as well as the standard resources such as grievances and treatment team meetings. The youth community meetings are held twice each month and the youth advisory board meetings are held on a monthly basis. A community meeting took place during the annual compliance review week. Five youth were interviewed to determine if the program has a process to allow youth to provide input about what happens at the program. All five youth indicated the program has a process to allow for youth input. An interview with the facility administrator (FA) confirmed youth are able to provide input during the youth advisory meeting, community meeting, and provide feedback by submitting a "Speak Out" form.

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

The program has an established community advisory board which consists of the facility administrator or designee, law enforcement representative, judiciary staff, community partners, individuals from the business community, school board, faith community, and the lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI) community. The advisory board also includes a victim advocate coordinator and parent/guardians of youth who were previously involved in the juvenile justice system. Documentation of sign-in sheets, agenda, and minutes were reviewed which reflected the community advisory board was conducted quarterly. It is noted the meetings were scheduled for ninety-day increments. An interview with an advisory board member indicated the advisory board meetings are conducted in collaboration with the Volusia Regional Juvenile Detention Center and the location of the meetings are rotated quarterly. The advisory board member reported the program was a good program, doing good things.

The facility administrator (FA) confirmed the members of the advisory board and added a Department of Children and Families (DCF) staff member, members from the United Way, and Stewart Marchman Act Behavioral Center. Meetings were reported held on March 28th, June 20th, September 19th, and scheduled for December 12, 2019. The FA explained the involvement of the board is a collaborative effort to build relationships with individuals and institutions in the local community to help provide resources to the youth at the program to transition back into the communities as modeled citizens.

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

The program has a policy and procedures addressing a system of staff communication, opportunities to provide input, and feedback. An interview with the facility administrator (FA) indicated surveys are completed with the youth, parent/guardians, and staff. The information from the surveys are reviewed, considered, and shared during the general staff meetings. Monthly staff meetings provide staff with an opportunity to provide input and feedback regarding the operation and areas of improvement of the facility. The FA conducts a weekly morning management meeting including all administrative staff and the results of these meetings are entered into a database with results compiled by corporate staff. Five staff were interviewed on how often staff meetings are held. All five staff reported staff meetings are held monthly and two staff commented occasionally staff have participated in off-campus meetings. All five staff indicated staff meetings were valuable, informative, and listed helpful program topics discussed. All five staff were interviewed on the communication among the staff. Two reported very good and three stated good. All interviewed staff stated they were not informed of program reports such as the annual report or surveys completed by youth or parent/guardian. All five staff responded in the affirmative on whether they can provide input or feedback on program operations. An interview with the FA listed staff incentives to address staff turnover and morale including employee of the month, monthly drawings to recognize employees, referral bonuses, safety committee to nominate employees who practice safe work habits and staff pot luck events. The FA advised the Comprehensive Accountability Report (CAR) report is shared with staff in all staff meetings to discuss decreasing recidivism of released youth. The FA further stated, program changes and development are addressed during shift briefings before the beginning of the shift and in monthly 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 written policy and procedures addressing a system for evaluating staff, performance standards, and frequency of evaluations. Evaluations for staff are completed annually. A sample of seven staff performance evaluations were reviewed for administrative/supervisor, case management, and therapists. Evaluations are conducted on an annual basis and include job specific performance standards. Performance standards matched the job descriptions for each staff and included job specific requirements of the position. Five interviewed staff reported on often staff receive formal evaluations based on performance standard. Two staff stated yearly and two staff stated every six months. The additional staff comments were once a year but could be six months, and was not sure only one monthly evaluation was received so far. An interview with the facility administrator (FA) reported all employees are evaluated annually in October.

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

The program provides a variety of recreation and leisure activities. A review of the activity schedule includes recreation and leisure activities. Logbooks were reviewed for recreational activity which confirmed this practice. Recreation was observed during the annual compliance review. Ratio was initially not in compliance but was corrected immediately. Youth were observed to engage in basketball and throwing a football back and forth.

Five interviewed youth and staff confirmed the program provides recreation and leisure activities daily. The interviewed youth and staff reported depending on the weather, recreational activities are usually basketball, football, sometimes kickball or soccer. Three staff also explained the indoor leisure activities range from watching movies/television, playing video and board games, and playing cards.

Standard 2: Assessment and Performance Plan

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

Five youth case management records were reviewed and all five records indicated the program notified the youth parent/guardian by telephone within the twenty-four hours of admission as required. Five youth case management records indicated the program notifies the parent/guardian in writing within forty-eight hours of the youth's admission to the program. Five youth case management records were reviewed and all five records included documentation to support the committing court and juvenile probation officer (JPO) was notified within five working days of the youth's admission to the program.

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

Five youth case management records were reviewed and all five records indicated the program provides each youth with a program orientation within twenty-four hours of admission. Orientations included all required elements such as services available, expectations, responsibilities, access to medical services, access to the Florida Abuse Hotline, and access to mental health services. Five youth were interviewed and all youth responded they received orientation within twenty-four hours of admission into the program.

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.	

A review of three youth case management records for youth eighteen years of age or older, indicated the program had documentation of consent before discussing physical or mental health screenings, assessments, and treatment with the youth's parent/guardian.

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

Five youth case management records were reviewed and each record indicated the program had documentation the youth are initially classified on the date of admission. The program has a system in place for the purpose of classifying a youth's physical characteristics, maturity level, gang affiliation, assigning a youth to the living area and sleeping room, suicide risk factors to include medical, mental health, substance abuse, security, and special needs. All youth identified as having risk factors were entered into the Department's Juvenile Justice Information System (JJIS). Documentation was found to include reassessments for an increase in youth's privileges or freedom of movement and participation in work projects. The program does not offer off-campus activities.

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.	

Three youth case management records were applicable for review of suspected gang involvement. All youth entering the program are screened for gang involvement and affiliation. The local law enforcement, educational provider, the juvenile probation officer and law enforcement in the home county where the youth resides are notified. The program notified all parties in each of the youth case management records.

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.	

Three youth case management records were applicable for review of suspected gang involvement. Each youth's individual performance plan included gang prevention goals and each youth participated in gang prevention and intervention strategies. The program maintains a gang notebook which includes gang awareness and prevention training for the youth.

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

Five youth case management records were reviewed for the initial Residential Assessment for Youth (RAY) and Reassessments. Each record revealed the youth had a Residential Positive Achievement Change Tool (R-PACT) and/or RAY completed within thirty days of admission. The program conducted reassessments on the three applicable records within ninety-days after the completion of the initial RAY. Two youth case management records were not applicable due to their entry date to program. Initial assessment was entered in the Department's Juvenile Justice Information System..

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

Five youth case management records were reviewed. Four records contained documentation the Youth Needs Assessment Summary (YNAS) was completed within thirty-days of admission and was maintained in the Department's Juvenile Justice Information System (JJIS), as required. One record included the youth's YNAS was completed after the return from a mandatory hurricane evacuation, which caused the YNAS to be a few days late.

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

Five youth case management records were reviewed for performance plan goals based on the findings of the youth's initial assessment completed within thirty-days of admission. One performance plan was completed after the return from the mandatory hurricane evacuation. The treatment team was present during the development of the individualized performance plan. All five records indicated the criteria was met in the performance plan goals including specific delinquency intervention and measurable outcomes to decrease risk factors/increase protective

factors. There were individualized goals based upon the youth's prioritized needs which reflected risk and protective factors identified during the initial assessment process. The performance plans also included court-ordered sanctions which could be initiated and completed while the youth was in the program. Five youth case management records were reviewed for transition activities and all five records targeted the last sixty days of youth's stay. The youth and program were responsible to accomplish goals and there was a target date for completion. All three reviewed records had documentation supporting the program included the youth's noted gang involvement in the performance plan, when necessary.

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

Five youth case management records were reviewed with three records resulting in revisions to the youth's performance plan when determined necessary by the intervention and treatment plan. The program has a policy and procedures for intervention and treatment team to revise each youth's performance plan, when necessary. Revisions to the performance plans are based upon the Residential Positive Achievement Change Tool (R-PACT) and/or Residential Assessment for Youth (RAY) reassessment results, demonstrated progress or lack of progress towards completing a goal, or newly acquired or revealed information. Performance plan revisions were documented in all seven youth case management records.

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

Five youth case management records were reviewed with three of the performance summaries at ninety-day intervals. Ninety-days intervals began from the signing of the youth's performance plan or at shorter intervals when requested by the committing court were completed. Two youth case management records were not applicable due to the entry date into the program. All summaries included the youth's status on each performance plan goal, treatment progress, academic status, behavior, level of motivation or readiness to change, interaction with peers and staff, the overall behavior adjustment to the program, and significant positive and negative changes. Transmittals were sent to the parent/guardian, committing court, and juvenile probation officer (JPO). All original summaries were found in the youth's record and were signed by all parties. Copies of the performance summary were sent to youth's JPO, committing judge, and parent/guardian within ten-days of completion of the summary. Five youth were interviewed and four youth responded they received a copy of their performance summary. The three closed records indicated a copy of the summary was maintained in the file and the original was sent to the JPO with the Pre-Release Notification (PRN).

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

Five youth case management records were reviewed. In all five records, the parent/guardian was involved in the case management/assessment process, invited to participate in the development of the performance plan, and were given progress reviews regularly. The youth's parent/guardian was contacted by telephone and the signature page of the performance plan was requested/returned with the parent/guardian signature. There were letters forwarded to the youth's parent/guardian informing them of formal treatment team meetings for the youth. The letters included the month, time, and year of the formal treatment team meeting. Five interviewed youth affirmed a parent/guardian were involved 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.	

Five youth case management records were reviewed and each youth had treatment team member's signatures or telephone participation. Treatment team members included a treatment team leader, the youth, an administration person, a living unit representative, treatment staff, educational staff, juvenile probation officer (JPO), and parent/guardian. There was also written input from living unit representatives, education, and medical staff.

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

Five youth case management records found each individualized performance plan referenced the youth's academic and treatment plan. Two of five records reviewed had involvement and with the Department of Children and Families.

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

Five youth case management records were reviewed for formal and informal treatment team reviews. Four were applicable for the formal treatment team reviews. One record was not applicable due to the youth's entry date to the program. Five records were applicable for informal treatment team reviews. Treatment team formal reviews were completed at least every thirty-days and contained the youth's name, date of review, attendees, and written comments from the treatment team, youth progress, revisions, positive and negative behaviors, and any physical interventions. Five youth were interviewed and each responded they have the opportunity during treatment team meeting to demonstrate skills they have learned at the program. Four of the five youth responded the staff review their performance which include

progress on performance plan goals, positive and negative behaviors, and treatment progress. Informal reviews were conducted at least bi-weekly and included the youth's name, date of review, attendees, comments from the treatment team members, youth progress, and any revisions. The reviews also included any progress made, positive and negative behaviors, any physical interventions, and any Residential Assessment for Youth (RAY) reassessment results.

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

The program has a policy and procedures to provide for career education. Three closed youth case management records were reviewed. All three youth records had a sample completed employment application, résumé, or documentation indicating they were completed online. The three youth closed records contained information about each youth's local Career Source Center's location and hours of operation. This information was included on the Youth's Plan for Success form and as a resource in their employability packet. The Youth's Plan for Success form also contained pertinent life skills information including interview skills, check writing, and filing a tax return. The program provides a Type 3 vocational competency development program required for programs with a contracted length of stay of nine months. The curriculum includes career technology education with a certification in Microsoft Office 2019. Career education is provided by the Volusia County School Board and according to the interview with the lead teacher, all youth are enrolled in career and technical education classes can earn certifications. The courses are all age appropriate and aligned with the youth's educational abilities and goals.

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 has a policy and procedures to provide for educational access. The program integrates education into the daily schedule in such a way to ensure the integrity of required minimum instruction time of 250 days of instruction distributed over a twelve month period with a minimum of twenty-five hours of instruction scheduled weekly. An interview with the lead educator indicated the school schedule is adhered to with little deviation. A review of the logbook verified the school schedule is typically followed. The youth interviews indicated minimal interference of education instruction.

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

The program has a written policy and procedures to provide for an educational transition plan. Three closed youth case management records were reviewed and confirmed the program's instructional staff and youth completed an education transition plan upon entry, which included services and interventions based on each student's assessed educational needs and post release education plans. The following key personnel related to transition were included in the development of the plan: the youth, parent/guardian, education representative, post release staff, school district personnel responsible for providing guidance services, and a designee of the Districts' Management Information System. All three youth case management records

included a request to the parent/guardians for documentation needed to obtain a Florida identification. One youth received their identification while the remaining two youth did not due to the documentation was not provided. All youth records included a Plan for Success form listing post release appointments and contact information for appointments needing to be scheduled upon release. The three youth records contained extensive life skills materials and resources such as interviewing skills, tax returns, job applications, résumé writing, college enrollment, and check writing.

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 youth closed case management records found all youth had transition planning including transition conferences which were held sixty-days prior to the youth's target release date. Documentation confirmed the youth, treatment team leader, facility administrator or designee, parent/guardian, and any other pertinent treatment team members were present during the conference. In addition, transitional planning is developed with the youth, education, program, and aftercare staff.

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.	

A review of three youth closed case management records found all records contained an exit portfolio. One of the three youth received their identification while the remaining two youth did not due to the documentation was not provided despite the program's request. All three portfolios contacted a transition plan and calendar containing follow up appointments. The portfolio also included completed sample job applications, résumé, vocational certificates, educational records, and school transcripts. Each youth record included the Electronic Educational Exit Plans (EEEPs) and/or referrals including educational recommendations. The program utilizes a form in which the youth and family signs stating they received their portfolio upon release.

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 youth closed case management records found finalized plans for the youth were completed prior to release. Documentation confirmed the youth, treatment team leader, facility administrator or designee, parent/guardian, juvenile probation officer (JPO) and any other pertinent treatment team members were present during the conference.

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 who serves as the designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the State of Florida which expires on March 31, 2020. The DMHCA is on-site five days a week for a total of forty hours each week and is on call as needed. The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services at the program. An interview with the DMHCA reflected services are being provided by the mental health therapy as indicted by the youth's individualized treatment plan. The DMHCA maintains an internal tracker to monitor the individual, family, and group counseling as well as fidelity checks to ensure services are provided in accordance with the treatment plans.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Non-Applicable
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 currently employees one licensed mental health professional, the designated mental health clinician authority and does not have any other licensed clinical staff.

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 two non-licensed mental health and substance abuse clinical staff providing services. Each staff member has a master's-level degree in counseling with a major in clinical mental health counseling. Each non-licensed clinician works forty hours each week with rotating weekends to ensure for seven-day coverage. Each non-licensed staff received at least one hour of weekly on-site direct supervision by the designated mental health clinician authority (DMHCA). The direct supervision was documented on a form with the required components documenting the date, time, duration, and to include the five sections of case load review,

clinical services, documentation, miscellaneous, and the Standardized Program Evaluation Protocol (SPEP). Documentation provided by the program reflected the non-licensed mental health and substance abuse clinical staff completed twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Each non-licensed therapist conducted at least five assessments supervised by a licensed mental health clinical staff. The program hired an additional non-licensed clinical staff on October 7, 2019 who was in the training phase at the time of the annual compliance review.

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 for standardized initial mental health and substance abuse screening which was signed by the designated mental health clinician authority (DMHCA) on July 1, 2019 and the psychiatrist on October 19, 2019. The program's screening is accomplished through the administration of the Massachusetts Youth Screening Instrument (MAYSI-2), Assessment of Suicide Risk (ASR), Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR), Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Beck's Depression Inventory (BDI-2), State Trait Anger Expression Inventory, Trauma Symptom Checklist for Children (TSCC), Reynolds Children's Manifest Anxiety Scale, and an Adolescent Substance Abuse Subtle Screening Inventory (SASSI). By policy, the program also conducts an admission classification meeting to review the youth's mental health, substance abuse history, MAYSI-2 screening findings, ASR screening findings, and the findings of the records review. The policy also addresses staff training in mental health and substance abuse issues.

Five youth mental health and substance abuse treatment records were reviewed for mental health and substance abuse admission screening. Each record contained a records review form which documented a review of the comprehensive evaluation, face sheet, commitment packet, and completed assessments. Each records review form was signed by the therapist and the DMHCA. Each record contained a MAYSI-2 completed on the date of the youth's admission by a trained staff member. Each screening was documented in the Juvenile Justice Information System (JJIS). Each completed MAYSI-2 indicated a need for further assessment and by policy each youth receives an ASR, a comprehensive evaluation, and psychiatric referral. Each record documented each youth received an ASR on the youth's date of admission. Each record contained a Mental Health and Substance Abuse Referral Summary reflecting a referral for a psychiatric evaluation. An interview with the facility administrator confirmed a MAYSI-2 and ASR are completed during the screening process to identify youth at risk for mental health and substance abuse problems and suicide.

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

The program has a policy and procedures in place which indicates all youth admitted to the program are automatically referred for a comprehensive mental health and substance abuse assessment which incorporates a psychosexual evaluation. Five reviewed youth mental health and substance abuse treatment records contained a new mental health and substance abuse evaluation completed within thirty days of admission. Each evaluation was signed by the clinical staff person completing the form and the designated mental health clinician authority (DMHCA) within ten calendar days of the evaluation being conducted. Each comprehensive evaluation contained demographics, the reason for the evaluation, relevant background information, behavioral observations, mental status examinations, and interviews administered. Each evaluation contained a discussion of the findings, the diagnostic impressions to include the DSM diagnosis, and recommendations. Each evaluation contained substance abuse information including patterns of alcohol and other drug abuse, the impact of alcohol and other drug use on the major life areas, and risk factors of continued alcohol or drug abuse. Each record contained a consent form for substance abuse services and consent for release signed by the youth, a staff member, and witness. The program has the required Chapter 397 licensure to provide outpatient substance abuse treatment services. The effective date of the license was April 8, 2019 and the license expires on April 7, 2020.

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

The program has a policy and procedures in place addressing mental health and substance abuse treatment and discharge planning. The policy outlines procedures for screening and review, alert systems, evaluations, treatment planning and review, the delivery of mental health/substance abuse and juvenile sex offender treatment services, and delinquency interventions. The policy reflects services include individual therapy, family therapy, and group therapy. Five reviewed youth mental health and substance abuse treatment records confirmed the youth are assigned a treatment team meeting upon arrival to the program. The multidisciplinary treatment team is compromised of the youth, program administration, residential living unit representative, and other staff involved in delinquency interventions and treatment services to include case management, mental health staff, the vocational instructor, medical staff, and the parent/guardian when available. Each record documented the youth was receiving group substance abuse counseling in accordance with their individualized treatment plan. Each record contained a properly executed Authority for Evaluation and Treatment (AET) and a signed Substance Abuse Consent and Substance Abuse Release form. All mental health and substance abuse treatment notes were documented on a progress note form which contained all of the required elements. Progress notes, observations, and sign in sheets confirmed mental health groups were limited to ten or fewer youth and substance abuse

treatment groups were limited to fifteen or fewer youth. Each youth received weekly individual counseling and sex offender specific group counseling. Groups are being provided by the licensed and non-licensed clinical staff working under the direct supervision of the licensed clinician. Four of five interviewed youth reported they participate in group and are receiving specialized therapy. Five interviewed direct care staff reported they do not facilitate any mental health or substance abuse groups. An interview with the designated mental health clinician authority (DMHCA) indicated mental health services are provided daily with sex offender specific counseling three days a week, two days a week of mental health specific groups, and two days a week of substance abuse treatment/prevention 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.*	

Five youth mental health and substance abuse treatment records were reviewed for treatment and discharge planning. Each record contained a completed initial treatment plan on the date of the youth's admission. The initial treatment plan was documented on a program form with all of the required elements and was signed by the mental health clinical staff completing the form. Two records documented the licensed mental health clinician completed the form and the remaining three plans were signed by the licensed clinician within ten days of completion. The initial treatment plans were also signed by the youth, case management, living unit representative, and other participants. Each initial treatment plan documented a referral to the psychiatrist for medication needs.

Five youth mental health and substance abuse treatment records contained an individualized treatment plan completed on a program form containing the required elements. Each individualized treatment plan was developed within thirty days of the youth's admission and was signed by the mental health clinical staff who completed the form. Four of the treatment plans were completed by a non-licensed clinical staff and each plan was signed by the licensed clinical staff within ten days of completion. The remaining record was completed by the licensed clinical staff. Each individualized treatment plan was signed by the treatment team members who participated to include the youth, parent/guardian if available, case management, mental health, living unit representative, medical, vocational, and education staff. Three of the five records reviewed were applicable for youth taking psychotropic medication. Each applicable record documented the psychotropic medication and the frequency of monitoring by the psychiatrist. Five youth mental health and substance abuse treatment records reflected each youth had a treatment plan review every thirty days following the development of the individualized treatment plan. The treatment team plan reviews were documented on a program form with the required elements. Three of five records contained progress notes which documented the youth received services as stipulated on the youth's treatment plan. The remaining two youth records did not document consistent family counseling sessions. One record did not contain documentation of family counseling sessions for four months with multiple

attempts to schedule a family session with the parent/guardian for one of the four months. One record reflected family counseling sessions were missed for two months.

The five youth mental health and substance abuse treatment records reviewed were not applicable for discharge plans; therefore, three additional closed records were reviewed. Each closed record contained a Mental Health/Substance Abuse Treatment Discharge Summary. None of the youth were applicable for being discharged on a suicide alert or suicide precautions. The discharge summary identified services needed for daily maintenance of the positive improvement made during treatment and services recommended for the youth upon discharge. Each record documented the discharge plan was discussed during the exit conference and a copy was provided to the youth, parent/guardian, and juvenile probation officer.

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

The program provides specialized sex offender specific treatment and has a bed capacity of thirty-three male youth. The DMHCA conducts psychosexual evaluations which are incorporated into the comprehensive mental health/substance abuse evaluation. The program conducts group counseling on a daily basis with juvenile sex offender groups being conducted three days a week, substance abuse groups conducted two days a week, and mental health groups conducted two days a week. Individual counseling is conducted once a week and family counseling once a month.

The designated mental health clinician authority (DMHCA) is on-site five days a week for a total of forty hours each week. Two non-licensed therapists are on-site forty hours each week and work rotating weekends for coverage seven days a week. The two non-licensed therapists are not juvenile sex offender therapists. The program contracts with a psychiatrist who provides psychiatric evaluations, medication management, and participates in treatment planning.

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

The program contracts with a psychiatrist who is to be on-site biweekly to conduct psychiatric evaluations, provide medication management, and render psychiatric services. The psychiatrist is board certified in child, adolescent, and adult psychiatry. The psychiatrist has a clear and active license in the State of Florida with an expiration date of January 31, 2020. The psychiatrist is available for consultation twenty-four hours a day, seven days a week. The program maintains documentation of the psychiatrist briefing the treatment team of the psychiatric status of each youth. Treatment recommendations made by the psychiatrist are incorporated into the youth's individualized mental health/substance abuse plan. A review of the sign-in and sign-out logs documented the psychiatric was on-site biweekly with one exception.

The program reported the psychiatrist had a scheduling conflict during this time. The designated mental health clinician authority (DMHCA) reported meeting with the psychiatrist on a biweekly basis and if any other need is identified. Five youth mental health and substance abuse treatment records were reviewed for psychiatric services. Each record documented the youth were referred for a psychiatric evaluation on the date of their admission. Three records documented the evaluation was conducted within fourteen days of being referred for the psychiatric evaluation. One record documented the psychiatric evaluation was completed three days late and the other evaluation was documented as being completed four days late. Each psychiatric evaluation included the youth's medical history, mental health history, substance abuse history, a mental status examination, diagnosis, and treatment recommendations. Three records were applicable for youth entering the program on psychotropic medications and their evaluations included an explanation of the need for medication related to the youth's diagnosis, target symptoms, initial treatment goals, potential side effects, risks and benefits of the medication, and the frequency of medication management. Each psychiatric evaluation included a Clinical Psychotropic Progress Note (CPPN). One record was applicable for a change to the youth's existing medication and was documented on the CPPN. The three applicable records for youth entering the program on psychotropic medication contained documentation the youth was seen for medication management with the psychiatrist at least once every thirty days.

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

The program has a policy and procedures addressing a suicide prevention plan which was signed by the facility administrator on December 13, 2018 and on October 7, 2019. The plan was signed by the designated mental health clinician authority (DMHCA) on December 13, 2018. The suicide prevention plan includes the identification and assessment of youth at risk of suicide, staff training, suicide precautions, and the levels of supervision including one-to-one supervision, constant supervision, and close supervision. The plan also includes the referral process, communication, notification, documentation, immediate staff response, and a review process for suicide attempts and mortality review.

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

The program has two non-licensed clinical staff and one licensed clinician who conducts Assessments of Suicide Risk (ASR). Each of the two non-licensed staff received twenty hours of the required training by a licensed professional including five co-assessments. The program maintains two suicide response kits which contains a knife for life, wire cutters, and needle nose

pliers. Confirmed through observations, one suicide response kit is maintained in master control in the dorm and the second kit is maintained in the administration/classroom building.
Two of five youth mental health and substance abuse treatment records were applicable for suicide prevention services. The regional mental health staff confirmed the program only had two youth applicable for being on suicide precautions since the last annual compliance review. Each ASR was completed on the required Department form. Each record reflected precautionary observation (PO) was authorized and supportive services were provided by mental health clinical staff. Each record contained a Follow-up ASR on the Department's form which was completed prior to the youth being removed from PO. Each ASR documented a conference was held with the program's director and licensed mental health professional prior to the reduction in the level of supervision and the ASR documented the date and time of the conference. Each youth was stepped down to close supervision in accordance with the program's suicide prevention plan. Documentation reflected each youth was maintained on close supervision until being cleared by the designated mental health clinician authority (DMHCA) for placement onto standard supervision. Each ASR was signed by the mental health clinical staff completing the ASR, the licensed mental health staff, and facility administrator (FA) as required. Each ASR was completed by a licensed mental health clinician or a non-licensed clinician under the supervision of a licensed mental health professional. Each ASR with the exception of one Follow-up ASR documented contact made to the parent/guardian and juvenile probation officer (JPO) to notify of the youth's potential suicide risk as indicated by the ASR. The Juvenile Justice Information System (JJIS) was reviewed and all applicable PO alerts were entered and closed after the youth was removed from suicide precautions. The youth on PO were not limited to their sleeping room and were able to participate in activities in designated safe housing areas. Each ASR was signed by the mental health clinical staff completing the ASR, the licensed mental health staff, and program administrator. The ASRs documented contact made to the parent/guardian and JPO to notify of the youth's potential suicide risk as indicated by the ASR. The facility logbook contained documentation of the youth being placed onto suicide precaution being transitioned onto close supervision and then placement onto standard supervision. Each ASR was completed within twenty-four hours of the youth being referred for an assessment and being placed on PO. Prior to each shift a staff briefing is conducted to review youth alerts and any pertinent information which occurred on the previous shift. Staff also review the facility logbook to ensure the information is passed on to staff during shift change. The DMHCA reported they meet with the FA on a daily basis and relays information regarding the status of mental health/substance abuse provisions, documentation, and coverage plans. Each record contained PO logs maintained for the duration a youth was on suicide precautions. The program does not utilize secure observation.

The program has a policy and procedures establishing a review process for any serious suicide attempts, self-inflicted injuries, and a mortality review for a completed suicide. The policy indicates the process will be multidisciplinary in nature and is to include but not limited to the FA and/or AFA, direct care staff, therapist, clinical director, case manager, director of case management, health services administrator, and other identified medical staff. The policy addresses a review is to include the circumstances surrounding the event, facility procedures relevant to the incident, all relevant trained received by involved staff, pertinent medical and mental health services involving the victim, and the possible precipitating factors. The policy addresses recommendations, if any for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

Four interviewed staff reported if a youth expresses suicidal thoughts, they are responsible for contacting mental health. One staff reported they notify their supervisor. Five staff stated they would also search the youth and room for sharp objects, maintain constant sight and

supervision of the youth, and document the supervision. Five interviewed staff were able to identify a suicide response kit is maintained in master control. Two of the five staff were able to verbalize a second suicide response kit is maintained in the administration building. The program administration reported they would review the locations of the suicide response kits with the staff at their next staff meeting. The program does not utilize secure observation.

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

Two of five youth mental health and substance abuse treatment records were applicable for suicide precaution observation logs. Each record contained suicide precaution observation logs on the required form and each log was maintained for the duration the youth was on suicide precautions. The staff documented checks at intervals not exceeding thirty minutes with one exception where a check was twenty minutes late. One of the two records documented a warning sign was observed and the log included signatures of the staff making the observation, the shift supervisor, and documented the youth was seen by mental health clinical staff. Each precautionary observation log documented the safe housing requirements and were signed by the shift supervisor and the mental health clinical staff. In addition, close supervision logs were reviewed for each youth. One of the two records documented checks of the youth not exceeding five minutes. The remaining record contained three logs for close supervision and documentation reflected eight late checks ranging from one minute to three minutes with one check being ten minutes late. The two applicable youth were interviewed and each youth reported staff were with them at all times while they were on suicide precautions and they were never left along for any period of time.

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

Five staff training records were reviewed for suicide prevention training and each staff member completed a total of six hours of suicide prevention training to include two hours in the Department’s Learning Management System (Skill Pro) and four hours of instructor led training. The program conducts monthly mock suicide prevention drills on each of the three shifts for all staff who come in contact with the youth. Documentation reflected all direct care staff with the exception of two staff participated in at least one quarterly drill semi-annually with the majority of staff participating in multiple drills. Documentation confirmed at least fifty percent of direct care staff participated in at least one mock drill which included the use of cardiopulmonary resuscitation (CPR) annually. The mock drills included documentation of the use of a two-way radio to call for assistance, the suicide response kit, automated external defibrillator (AED), and first aid kit. The mock drills also documented the simulation of contacting 9-1-1, the designated mental health clinician authority (DMHCA), and program administration. Staff members not present during the drills have the opportunity to review each drill scenario and procedures.

An interview with the facility administrator indicated the program conducts training or mock drills to include an emergency response to a suicide attempt or self-inflicted injury at least monthly on each shift.

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 addressing the program's crisis intervention plan which is separate from the program's emergency mental health and substance abuse plan. The plan was signed by the designated mental health clinician authority (DMHCA) on December 13, 2018. The crisis intervention plan addresses a notification and alert system, means of referral, including a youth self-referral, communication, and supervision to include one-to-one, close, and standard supervision. The plan also includes procedures for documentation and review.

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

Three crisis assessments were reviewed and each assessment was completed in response to a reported Prison Rape Elimination Act (PREA) allegation. Each assessment was completed on the date the PREA allegation was made. Each crisis assessment contained the reason for the assessment, method of assessment, mental status examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, and treatment recommendations. Each assessment included recommendations for follow-up, ongoing mental health treatment services, and applicable notifications. Each assessment indicated the youth were determined to not be in crisis and an alert was not applicable. One of the three crisis assessment was completed by a licensed mental health professional and two were completed by the non-licensed clinical staff working under the supervision of the licensed staff. Each crisis assessment was signed by the licensed mental health professional within twenty-four hours of the referral.

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

The program has a policy and procedures addressing an emergency mental health and substance abuse plan which is separate from the program's crisis intervention plan. The plan

was signed by the designated mental health clinician authority (DMHCA) on December 13, 2018. The plan includes the immediate staff response, notifications and responsibilities of the direct care staff, shift manager, facility administrator and DMHCA, communication, supervision, and authorization to transport for emergency mental health or substance abuse services. The plan also includes transportation for an emergency mental health evaluation and treatment under Chapter 394 for a Baker Act, transportation for an emergency substance abuse assessment and treatment under Chapter 397 for a Marchman Act, procedures for documentation, training, and a review process.

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's designated health authority (DHA) is a licensed osteopathic physician (DO) who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. The DHA's license expires on March 31, 2020. The DHA's specialty training is in family practice with experience with adolescents. The DHA does not designate a physician assistant (PA) or advanced registered nurse practitioner (ARNP). A review of the DHA sign-in and sign-out logs reflected the DHA is on-site weekly for two hours, as contractually required. The logs reflected there were no instances of nine or more days passing between on-site visits. If the DHA is on vacation or on a scheduled absence, coverage is arranged. During the DHA's absence, a medical doctor (MD) has been designated to perform clinical services and perform administrative duties. A copy of their credentials was available for review. The DHA is available twenty-four hours a day, seven days a week by phone and electronically for acute medical concerns, emergency care, and coordination of off-site care. The DHA reported covering all medical needs of youth in the program to include conducting comprehensive physical evaluations, providing periodic evaluations and treatment of chronic conditions, ordering diagnostics and lab work as necessary, referring to off-site providers when appropriate, discussing any potential and necessary changes in medical policy and procedure, and keeping close communication with the nursing staff to ensure proper care of the youth at all times. Additionally, the DHA reported being on-site two hours per week and can be reached via telephone at any time.

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

The program has written policies and procedures for all health-related procedures and protocols utilized at the program. The designated health authority (DHA) and facility administrator signs and dates all respective treatment protocols. Nursing staff reviews, signs, and dates a cover page on which all facility operating procedures (FOPs), treatment protocols, and other procedures are listed. New policies or changes in policies made during the year are reviewed, signed, and dated by nursing staff for changes which occur between annual compliance reviews. An annual review of all FOPs and protocols is completed by the program. All newly employed health care personnel receive a comprehensive clinical orientation to the Department's health care policies and procedures given by a registered nurse. A copy of the health care staff orientation packet was provided by the program. Approval of treatment protocols or standing procedures are written and authorized by the DHA and are not delegated to any other person. The review and development of FOPs or other protocols related to psychiatric services and psychotropic medication management is performed by the program's psychiatrist.

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

The program has a written policy and procedures ensuring the completion of an Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in their custody. Five youth individual health care records (IHCRs) were reviewed for an AET. All five reviewed records contained an AET each of which were stamped "copy" in blue ink. AETs are valid until the youth's eighteenth birthday. Copies of parental notifications were maintained behind the AET in the IHCR. According to the nurse, the Juvenile Justice Information System (JJIS) is checked for each youth prior to admission for an AET. If a youth is received without an AET, nursing staff contacts the assigned case manager who then contacts the assigned juvenile probation officer (JPO).

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

Five youth individual health care records (IHCRs) were reviewed for parental consent. Each record reflected documentation of parental notification for over-the-counter (OTC) medications beyond what is covered in the Authorization for Evaluation and Treatment (AET). Two of five records reflected consent for changes in existing medication. One record reflected documentation of notification for discontinuation of a prescribed medication. Two records reflected notification for off-site care. Three records reflected notification for new medication. Written notifications are sent regardless of telephone notifications. Documentation reflected staff members witness telephone calls and conversations. Three applicable youth for psychotropic medication reflected parent/guardian consent on page three of the Clinical Psychotropic Progress Note (CPPN). All three applicable records reflected the CPPN had been mailed out for parent/guardian signature. None of the youth reviewed were applicable for involvement with the Department of Children and Families due to parental rights being terminated. All youth admitted to the program had their immunization records verified within thirty days of admission through Florida Shots. None of the youth reviewed were applicable for refusing consent or refusing consent due to religious reasons. According to nursing staff, immunization records are reviewed and verified upon a youth's admission through Florida Shots.

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

The program has a written policy and procedures ensuring youth receive a routine health care screening and evaluation upon admission to the program. Five youth individual health care records (IHCRs) were reviewed for completion of a Facility Entry Physical Health Screening (FEPHS) form. Documentation in five reviewed records reflected a FEPHS was completed on the day of admission for each youth. Three of the five records reflected the FEPHS was completed by a registered nurse (RN) and two reflected they were completed by a licensed practical nurse (LPN). One of five youth records reviewed was applicable for a rescreening, two additional records were provided by the program. Documentation reflected each of the three

applicable youth had a health admission rescreening on the day they returned to the program by a RN or LPN.

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

The program has a written policy and procedures in place for all youth to be orientated to the program's health care system upon admission or the next available opportunity. Five youth individual health care records (IHCRs) were reviewed for completion of orientation to health care services. Documentation in all five records reflected each youth received health care services orientation upon admission to the program, as indicated by the youth signature and date of the healthcare orientation packet. The program's health care orientation included access to medical care, sick call, medication monitoring, what constitutes an "emergency," the right to refuse, what to do in the event of sexual assault, and the non-disciplinary role of healthcare providers.

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

Five youth individual health care records (IHCRs) were reviewed for designated health authority (DHA) notification upon admission to the program, if applicable. None of the five reviewed records were applicable for DHA notification for a chronic condition. None of the five reviewed records required immediate notification for need of emergency services. It is the program's practice to notify the DHA for all admission to the program regardless of chronic conditions. All five reviewed records reflected the DHA was notified by telephone for each youth upon admission to the program. The DHA notification was documented in the chronological progress notes for each youth.

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

Five youth individual health care records (IHCRs) were reviewed for completion of a Health-Related History (HRH). Documentation for all five records reflected each youth had a HRH completed on the day of admission to the program. The program completed a new HRH for each youth. All five HRHs reviewed were completed by a nurse and subsequently reviewed by the designated health authority (DHA). All five HRHs were completed before the Comprehensive Physical Assessment (CPA).

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

The program has a written policy and procedures to ensure each youth physical health evaluations subsequent to admission to the program. The program utilizes the Department's

Comprehensive Physical Assessment (CPA) form. Five youth individual health care records (IHCRs) were reviewed for completion of a CPA. Each of the five reviewed records reflected a new CPA was completed by the designated health authority (DHA) within seven calendar days of admission to the program. Three of the five youth entered the program as a medical grade five and two entered as a medical grade one. Each CPA was completed in accordance with the Health Service Manual requirements. All sections of the CPA were marked with an "O" or an "X". Those sections marked with an "X" reflected comments by the DHA in the comments section of the form. The statement "deferred by clinician" was observed on applicable sections of the exam. None of the youth refused any part of the examination. The Problem List was observed to be updated for all five youth. The program has a written policy and procedures ensuring youth who enter the program are screened for latent or active tuberculosis (TB) as well as environmental controls for the program. The written policy and procedures were observed to be in compliance with the Centers for Disease Control and Prevention new 2006 recommendation and Occupational Safety and Health standards. Each of the five IHCRs reflected each youth had a verified tuberculin skin test (TST) completed in the last year. All five IHCRs indicated each youth received tier I B screening was completed on the day of admission to the program. Each youth was assessed prior to being placed in the general population. The results of the TST were observed to be documented on the CPA and Infectious Communicable Disease (ICD) forms in all five records reviewed. According to the nurse, CPAs are completed by the DHA within seven days of admission to the program. Additionally, the nurse reported the TB screening process is the nursing staff provides the youth with a TST within seven days of admission if the youth have one of the symptoms listed in the program's policy or if there is no documentation reflecting one has been given within twelve months. Nursing staff check results of test in forty-eight to seventy-two hours and document all within the tuberculosis testing log and in the IHCR.

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

The program has a written policy and procedures to ensure each youth receives a sexually transmitted disease/infection (STI) screening, evaluation, and testing. Five youth individual health care records (IHCRs) were reviewed for STI screening. Documentation reflected five youth were screened for STIs. Four of the five youth were referred for STI testing. Testing, screening, results, clinical evaluation, and diagnosis were found to be documented on the Infectious and Communicable Disease (ICD) form. None of the five youth reviewed were out of the Department's custody where a re-screen would be required. Referrals for testing for four of the applicable youth were documented on the STI screening form. Testing for four applicable youth was documented in the youth's progress notes. The program has a written policy and procedures in place to ensure all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, referral for medical treatment as indicated, education, and prevention counseling. Each of the five reviewed records reflected youth were offered testing, counseling, and treatment upon admission to the program. Documentation reflected all five youth consented to testing. Test results were observed filed in a confidential manner consistent with F.S. 381.004, a certified HIV counselor conducted the testing, and a youth's HIV status is never included with the internal alerts. HIV testing is completed by Community Outreach which is an affiliate of the Volusia County Health Department. Observation of pre-counseling and post-test counseling were documented in all five youth's health education record within their IHCR. A copy of the provider's 500/501 certification was available for review. Five interviewed youth reported they could request HIV testing.

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

The program has a written policy and procedures to ensure a system is in place to respond to the complaints of a youth illness or injury of a non-emergent nature. Five youth individual health care records (IHCR)s were reviewed for sick call. Two of the reviewed five youth IHCRs were applicable for sick call, the program provided an additional record for review. None of the three reviewed applicable youth IHCRs reflected similar sick call complaints three or more times within a two week period. None of the three youth present with complaints in which medical staff were unfamiliar with. All three youth completed sick call request forms which were placed in a locked box and then provided to the nurse. Completed sick call request forms were observed filed with the corresponding progress note for each youth, in reverse chronological order. Two of the three sick calls reviewed were completed by a registered nurse (RN) and one was completed by a licensed practical nurse (LPN) in which the RN subsequently reviewed. The program does not use restricted housing. When a licensed nurse is not on-site, the program has procedures in place whereby the shift supervisor reviews all sick call requests as soon as possible or within four hours of the request being made. Sick call is conducted daily at the program between 1:00 p.m. and 2:00 p.m. Progress notes were observed to be documented in accordance with Health Services Rule 63M-2. Sick calls were observed documented on the youth's sick call index in the IHCR as well as the Sick Call Referral log. Sick call forms were observed to be available to youth throughout the program. Observation of sick call hours are included on the daily activity schedule which was posted throughout the facility. Youth privacy during sick call encounters is ensured. One sick call was observed during the annual compliance review. The reviewer obtained the youth's permission to observe the sick call. The youth was escorted to medical by a Protective Active Response (PAR) certified staff member. The nurse conducting sick call was also PAR certified. The nurse identified them self and stated why the youth was there. The youth signed they were seen, was seen in a private area, and proper equipment was present.

Four of five interviewed staff reported the nurse responded to sick calls, one responded the doctor. Two of five interviewed youth reported they were seen immediately after placing a sick call, two reported within one day, and one reported within three days.

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

The program has a written policy and procedures in place to provide twenty-four hour emergency medical, mental health, and dental care to youth, as needed in response to unexpected illness, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. Five youth individual health care records (IHCRs) were reviewed for episodic care. Four of the five youth were applicable for episodic care. None of the four youth reviewed were referred for off-site care. Progress notes contained all required elements, referral needed, parental notification, and plans for follow up/future care observed. On-site care provided by licensed healthcare staff and subjective, objective, assessment, and place (SOAP) format was observed. The Episodic Care log documented all

instances of first aid/emergency care. Logs for the previous six months corresponded with all on-site and/or off-site events observed in the youth records. Emergency medical and dental care including EMS services are available twenty-four hours a day. The program has twelve first aid kits. First aid kits are located in master control, case management, administration, education, medical, and both kitchen areas. The program has two suicide response kits, one located in master control and one in administration. The first aid kits were fully stocked with designated health authority (DHA) approved contents. The first aid kits are monitored weekly by nursing staff to ensure they are secured and monitored monthly to ensure inventory. The program has one automated external defibrillator (AED) which is located in master control. Instructions are located inside the AED. Nursing staff inspects the AED once a month. AED inspections for the previous six months were available for review. The registered nurse (RN) performed a self-test of the AED during the annual compliance review. The AED pads expire on July 4, 2022. The AED batteries were last changed on July 4, 2018. The current AED pads expire in October 2020. The AED pads were last changed on October 3, 2019. Per the program's written policy and procedures, the program conducts medical drills monthly on each shift. A review of drill documentation reflected the program has conducted drills monthly and on each shift since the last annual compliance review. Additionally, drills included the use of cardiopulmonary resuscitation (CPR)/AED or the administration of first aid quarterly and on each shift. If staff are not present for the drills, they can review the drills at monthly all staff meetings. The program has a list of emergency numbers including the Poison Control Information Center. These numbers are inaccessible to youth. The program has an approved list of non-licensed health care staff who are able to assist youth with medication administration or use of an epinephrine auto-injector. All staff on the approved list are supervisory level staff members or higher. A review of training records for these staff indicated they have completed the required training. The program has a list of emergency numbers including the Poison Control Information Center. These numbers are inaccessible to youth.

Five interviewed staff reported they can call 9-1-1 in the event of a medical emergency. Five youth reported they can see a dentist if they have tooth pain. Five interviewed youth reported they can see a doctor, if needed.

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

The program has a written policy and procedures ensuring the program will provide timely referrals and coordination of medical services to an off-site health care provider (emergent and non-emergent). Five youth individual health care records (IHCRs) were reviewed for off-site care. Two of the five youth were applicable for off-site care. The program provided an additional record for review. Two of the three IHCRs reflected documentation of parental notification for one youth who was eighteen years of age. Three IHCRs records reflected completion of the Summary of Off-Site Care form. Discharge documents were observed filed in two of the three IHCRs. The designated health authority's (DHA) signature was observed on all three off-site care findings, instructions, and information. All three youth required follow-up appointments. Observations of documentation of referrals and follow up appointments were documented in the progress notes for each youth.

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

The program has written policy and procedures ensuring youth who have chronic conditions receive regularly scheduled evaluations and necessary follow-up. Five youth individual health care records (IHCRs) were reviewed for chronic conditions. None of the five records reviewed were applicable for chronic conditions. The program provided three additional applicable records for review. Two of the three applicable youth IHCRs reviewed were identified with a chronic condition on the Facility Entry Physical Health Screening (FEPHS) form. None of the three youth reviewed had a communicable disease. Two of three youth were taking prescribed medication on an ongoing basis and one youth was undergoing treatment for a body mass index (BMI) greater than thirty. Two of the youth reviewed was classified with a medical grade of five and one with a medical grade of two. All three youth were observed to be identified as having a chronic illness on the program's internal alert roster. None of the youth IHCRs reviewed were taking ant-tuberculosis medication. Periodic evaluations are tracked by nursing staff by using an excel spreadsheet designated for chronic conditions and periodic evaluations. Documentation reflected all three youth received periodic evaluations every sixty days and there were no instances of lapses in care or missed periodic evaluations. None of the periodic evaluations were conducted off-site. The Problem List for each youth was updated in accordance with the Health Service Rule 63-M. Periodic evaluation documentation was observed in each youth's IHCR. Evaluations are conducted prior to the renewal of a prescription medication about to expire. Treatment orders were observed to be written clearly distinguishable for clinical staff.

According to the facility administrator (FA), shift briefings are held prior to all shift to discuss any identified issues with youth. Additionally, the FA reported monthly all staff meetings are held and at this time health care staff review important medical issues with youth. Both nursing staff and the designated health authority (DHA) were able to explain the process for monitoring youth with chronic conditions.

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

The program has a written policy and procedures in place ensuring all youth receive prescription medication(s) as prescribed. Five youth individual health care records (IHCRs) were reviewed for prescribed medication upon admission to the program. Three of the five reviewed IHCRs reflected the youth were prescribed medication upon admission to the program. Prescription verification for all three youth was observed in the chronological progress note in the record. After the verification process, documentation reflected the registered nurse (RN) contacted the designated health authority (DHA) and psychiatrist to resume the medications. All medications were observed to have a current, valid order and are given pursuant to a current prescription. The program does not utilize restrictive housing. Two of the three youth reviewed were applicable for over-the-counter (OTC) medication not listed on the Authority for Evaluation and Treatment (AET) in which medication was administered according to approved protocols. The Medication Administration Record (MAR) utilized by the program is pre-printed by the pharmacy. Staff initial each administered medication. There were no undocumented

explanations for lapses or errors in medication administration. Nursing staff document weekly side effect monitoring on the MAR. The Six Rights of Medication Administration are maintained by both licensed and non-licensed staff. One of the three applicable youth's MAR reflected a refusal which was clearly documented on the MAR and corresponding refusal form. The Facility Entry Physical Health Screening (FEPHS) for indicated all three youth were taking prescribed medication upon admission to the program. Appropriate notifications to the parent/guardians were made for all three youth IHCRs reviewed. All medications were observed to be in a separate, secure areas inaccessible to youth. All non-controlled medications prescribed and OTC are stored in a separate, secure, locked area inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stocked items are stored separate from specific youth medications. All expired medication is destroyed once a month when the pharmacist visits the program utilizing Rx Destroyer. Medication pass was able to be observed during the annual compliance review with no issues noted.

Four of the five interviewed staff reported the nurse administered medication to youth and one reported the doctor administers medication. Four of the five interviewed youth reported a nurse administers their medication and was able to explain the medication administration process. One youth reported not taking medication.

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

The program has a written policy and procedures ensuring all chemical products, drugs and medicines, and medical instruments assigned to the medical department are securely stored, regularly inventoried, disposed of, and properly maintained in accordance with federal and state laws. Medical equipment classified as sharps were observed securely stored and inventoried by using a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Observation of medications such as injectables, topicals, drops, and liquids were separated. All observed controlled substances were maintained behind two locks, stored separately from other medications, and had a perpetual inventory. The program has a process in place for disposal or destruction of expired and discontinued medications. A perpetual inventory of all sharps and stock over-the-counter (OTC) medications was observed. Pursuant to the Board of Pharmacy regulatory requirements, observation of a shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record. A first and second shift of controlled medication was observed, the program does not have a third shift for medical staff. The program maintains an approved list of supervisory level non-health care staff trained in the delivery of medication self-administration in the event nursing staff is not on-site. The reviewer observed the nurse inventory two youth medications being a narcotic/controlled medication, three OTC medications, and three sharps all of which matched the perpetual inventory. The nurse was able to explain the procedures for inventory discrepancies. Perpetual inventories of medications and sharps for the previous six months were available for review. The nurse was able to explain the program's process for secure storage and routine inventories of medication, disposal of medication, and the practice for securing controlled substances.

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

The program has a written policy and procedures addressing infection control. The program's infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, as per Occupational Safety and Health Administration (OSHA) federal regulation and the Center for Disease Control (CDC) guidelines. The program's infection control procedures include common infection diseases of childhood, self-limiting, episodic contagious illness, viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV, pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. Additionally, the hepatitis B immunization is available to staff. There were no instances in which the local health department, CDC, or the Central Communications Center (CCC) should have been notified. The program has a comprehensive process for needle stick post-exposure evaluation. The facility administrator or designee will maintain a separate file containing all documents for youth and staff who have experienced facility exposure, as necessary. The program's exposure control plan was found to be written in accordance with OSHA standards. The plan is available to all staff. The plan is reviewed and signed annually by the FA. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure.

The FA reported the exposure control plan is located in master control and medical and reviewed with staff annually.

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures addressing youth supervision. According to the written policy and procedures, the following program staff to youth ratios are followed one to six during awake hours, one to eight during sleep hours, and one to five for off-site activities. The program's written policy and procedures define active supervision as the use of effective and efficient supervision which includes positive contact, positive reinforcement, structured activities and random/predictable movement which provides suitable and timely response to the everyday needs of the youth and immediate response to emergencies while maintaining the safety and security of the program. Observations of youth were made each day of the annual compliance review to include movement entering and exiting classrooms, youth movement to and from the living areas and cafeteria area, groups, and historical video surveillance footage. Staff to youth ratio was observed to be in compliance each day. Positive interactions were observed with staff and consistent application of the behavior management system was observed. Staff were randomly questioned on the number of youth they were supervising. Staff were able to accurately report the number of youth and ratios were met. The daily activity schedule reflected a full schedule of activities planned. Observation of the daily schedule was posted throughout the program to include the youth living areas. Staff appeared to be closely monitoring the youth under their supervision. At no time during the annual compliance review, youth were observed to be unaccompanied.

Five of the interviewed staff were able to explain what to do in the event a discrepancy in the count was found.

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

A review of the program's policies and procedures revealed the provider is ensuring youth in their care are provided a safe therapeutic environment. The established behavior management system (BMS) is promoting positive social change and holding youth accountable for their behavior through behavioral expectations. The program's BMS is clearly written, posted throughout the program, and is included in the youth handbook. A review of five youth records revealed all contained, signed, and dated receipts of the orientation handbook. Observations throughout the annual compliance review reflected a consistent implementation of the BMS by staff to include adherence to the four to one ratio of positive to negative consequences. The

youth's progression through the levels of the BMS is indicated as minor league, rookie, major league, and most valuable player. Negative consequences are in direct relation to the severity or seriousness of inappropriate exhibited behavior. Five of interviewed staff were able to explain the BMS system and the levels in which youth progress through the program. Four interviewed staff stated when youth are given behavior referrals they are given the opportunity to provide feedback in the comments section of the referral. Five interviewed youth were able to explain the BMS level system. Three interviewed youth i reported consequences could include getting "benched" for behavior referrals and/or the loss of other non-specific extras. Five interviewed youth reported rewards include food, snacks, movies, games, and reward parties for completing certain milestones.

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

The program's written policy and procedures ensures a protocol in which staff is provided feedback regarding their implementation of the behavior management system (BMS). The facility administrator (FA) and youth advocate oversee the consistent implementation of the BMS. The BMS is tracked by the youth advocate through an excel spreadsheet. The spreadsheet contains a log of the total days earned for each youth, level status, violation report, and the status of earned days by date. Each week youth level status sheets are posted in the dorms. Youth level sheets were observed to be posted in the dorms. An incentive calendar was also posted in the dorms. The BMS is reviewed in management team meetings and monthly campus-wide meetings for staff and teachers. Sample position descriptions were available for review and included the required qualifications of staff whose job functions included implementation of the program's BMS. The provider's contract included all required parties were involved in the development, implementation, and on-going maintenance of the BMS. The BMS allows staff to explain the reason for any sanction imposed on a youth and the youth is given an opportunity to explain their behavior. The BMS does not include increased length of stay, denial of basic youth rights, promotion of group punishment, punishment by other youth, or disciplinary confinement. The program does not use room restrictions. Ten staff training records were reviewed for BMS training. Documentation reflected staff received pre-service and in-service BMS training on an annual basis with regard to in-service training.

Five interviewed youth reported youth are not allowed to punish other youth. All interviewed youth reported staff are consistent in the use of rewards to some degree or another. Three youth rated the BMS as good and two as fair. All five interviewed staff reported youth are given behavior reports for rule infractions and these infractions are discussed with the youth at the time. One staff reported behaviors are discussed at treatment team meetings. Three interviewed staff reported the BMS is discussed at briefings each day. According to the FA, BMS violations are reviewed for consistency and if necessary, staff will be retrained on the use of the BMS or coached on the proper use of the system. Additionally, a review of the FA interview responses

reflected the BMS is a positive performance system where youth complete their goals daily with the assistance of the staff. Rewards are achieved and celebrated through monthly and weekly award ceremonies and incentives. Youth are also provided acknowledgements of “Do Rights”.

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

The program has a total of twenty-four cameras in which all of them are currently operational. The program stores video footage for thirty-days. The program currently has three staff shifts and there is one living unit where all youth in the program are housed. The program is required to complete room checks every ten minutes; however, it is the program’s practice to conduct room checks every eight minutes. Video surveillance footage was observed for six separate occasions. All six time frames observed were for each of the three shifts. All checks were observed to be completed as required and documented in real time. In addition, staff were observed utilizing flashlights and going from room to room conducting youth checks.

Four of the five interviewed staff reported room checks are conducted every eight to ten minutes while youth are sleeping. One staff member reported checks are conducted every ten minutes.

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

A review of the program’s policies and procedures reveal they address youth census, counts, and tracking. Reviewed logbooks for the past six months confirmed counts are completed during the approximate times specified in the policy. Reviewed logbooks indicated proper counts were taken and cleared after a qualifying emergency as well as periodic simulated drills to enable the implementation of proper count procedures. Logbooks documented new admissions, releases, and when youth were taken off-site. There was one observation on June 4, 2019 in which the admission of a new youth was not clearly noted in the logbook. The youth headcount is also documented on the shift report log for briefing purposes. Two program formal head counts were observed. Each count was controlled, accurate, and cleared without issues.

The program followed proper Continuity of Operations Plan procedures on August 31, 2019 when the program was forced to evacuate all youth and staff. A Central Communications Center incident report was generated.

Five staff were interviewed and all staff indicated the master count is conducted every hour and after each youth movement. Additionally, al staff stated a master count should be conducted after a disturbance or a recount after any discrepancy.

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.	

A review of the program's policies and procedures revealed the provider address logbook entries and shift report reviews. The policy addresses the requirements outlined in standard 5.06 and a review of the logbooks for the previous six months revealed the overall appropriate utilization of the program logbook. There were some minor inconsistencies with regards to the written shift supervisor notes. These minor inconsistencies were not observed enough to be consistent with an exception. A recommendation was made to the facility administrator during the annual compliance review to ensure more thorough documentation in the daily shift logbook.

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

The program's policies and procedures for key control address assignment of keys, tracking of keys, missing or lost keys, and reporting of and replacement of damaged keys. Training on key control has been provided to staff. Visitors must turn in personal keys before entering the program. A visual inspection was made of all four key storage locations. The main key storage and visitor key storage are stored in the administration building. Staff and visitors turn in their personal keys and receive their assigned keys for the day, this process is reversed upon egress. There is also locked key storage in the maintenance office, medical office, and a fourth location which contains a duplicate back up copy for all the program keys. The issuance of each staff key is documented. Key box one contains all spare/duplicate keys, restricted keys, emergency keys, and is secured in a lock box in a locked office. The locked medical key box contains keys to the medication cart and over-the-counter medication and cold medication storage. A review of the key inventory found one discrepancy in which key twenty-three was identified on the key inventory log as having four keys in which one was a cuff key was found to not contain a cuff key. The program updated their key inventory as a result.

Five staff were interviewed and each were aware of the process for lost or missing keys and the program's policy for reporting and replacing damaged keys. All staff were aware to receive the

keys they were required to and provide their personal keys. The program maintained a key control log for the keys being issued to the staff.

5.08 Contraband Procedure	Satisfactory Compliance

The program's policy must address illegal contraband and prohibited items.

A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.

The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.

The program's policies and procedures address contraband to include identification of items considered to be unauthorized and/or illegal contraband and the confiscation and removal of contraband. A review of the program's contraband and search logbook revealed random youth room searches were conducted throughout the period of the annual compliance review. A random sample of program logbooks, youth search forms, and contraband logbooks were conducted to verify youth room searches were conducted. The program maintains a contraband and search log which documents youth room contraband searches. A random selection of these contraband search on June 22, July 6, August 23, and October 16, 2019 were used and compared to the program logbook. The program logbooks do not document the contraband searches were conducted. Program logbooks included documentation of perimeter checks. All youth are provided a resident handbook at intake which identifies in detail what contraband is, what items will be searched, and the proper disposal of contraband by the program staff or law enforcement, if needed.

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's contraband and search log revealed youth searches were conducted both for transport, and new admissions. The program's policy and procedures address searches and full body visual searches of youth. Observations of staff performing youth searches was conducted on several occasions of youth movement throughout the program. Searches were conducted by male staff of the same gender as the youth. Staff conducting searches were respectful of youth during the search. A review of the program's contraband and search log indicated documentation of youth searches being performed upon youth entry into the program and each time of re-entry, when applicable.

Five staff interviews and five youth interviews were conducted. Five youth reported being searched when returning from off-campus activities. Five staff and youth reported searches were conducted after returning from outdoors, three reported when items went missing, four youth reported after visitation, two reported after meals, and two reported after work detail.

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

The program's policies and procedures address vehicles and maintenance. The program has four transport vans. Two of the transport vans are no longer in use and have been surplused. Vehicle maintenance records and an annual inspection were documented for each of the two remaining vans in use. Each vehicle used to transport youth was visually inspected by the review team member utilizing a vehicle checklist. Each van was equipped with all necessary safety equipment items including glass punch, seat belt cutter, fire extinguishers, and appropriate number of seatbelts. The program does not keep a sealed/unopened first aid kit in the transport van when unoccupied. A first aid kit is acquired from the main control room prior to departure. Upon initial inspection, one transport van was observed with an unlocked back door which was brought to the attention of the facility plant manager.

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

The program's policy and procedures addressed transportation of youth. Five staff were interviewed regarding youth transports. All three staff stated they are not allowed to use personal vehicles during youth transport. All five staff reported the use of cell phones and/or hand-held radios during youth transports. According to the provider's policy and procedures, driver license checks are not conducted routinely for all program staff. According to the policy, it is the responsibility of the individual staff to notify their corresponding shift manager of any license suspension or revocation. Staff take their personal cell phone during youth transports which allows communication with the program. Staff do not transport youth in their personal vehicle and never allow youth to drive program or personal vehicles. During the random inspection of staff personal vehicle's, it was noted one vehicle was found with its back-hatch door unlocked. This was brought to the attention of the facility plant manager.

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

The program has a written policy and procedures ensuring the safe and efficient operation of the physical plant which protects against the development of conditions which may adversely affect the health, safety and wellbeing of youth, staff, and visitors. The written policy and procedures outline who is responsible for conducting the weekly security audits and safety

inspections, the development and implementation or corrective actions warranted as a result of safety and security deficiencies found, and an internal system to verify deficiencies found are corrected. According to the written policy and procedures, the physical plant manager is responsible for conducting weekly safety audits. In addition, the physical plant manager will review the completed form with the facility administrator (FA) and have the FA sign and date the audit form. Additionally, a review of the FA interview responses indicated safety and security is addressed by the program during weekly safety and security audits, and daily perimeter checks on each shift. The program addresses the issues identified through the safety and security checks by setting target dates for completion by working with the physical plant manager or outside vendors.

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.	

An inventory of the kitchen, operations, and the maintenance tools was conducted. During a review of the tool room, a random check from the official inventory list was conducted. There were no tools found to be missing or damaged. All tools observed were clearly identified with a tool number. The shadow board clearly outlined all tools with an identification number for the tool being placed there. A review of the outside tool shed also revealed there were no missing or damaged tools based on random selection of tools from the official tool inventory sheet. All tools in the tool shed and the tool room were properly documented by the staff signing out and signing in the tools utilized. There were no cooking tools or knives noted as missing or damaged. Each tool and/or knife was properly labeled with a tool number and all were accounted for. All tools were properly stored in a locked cabinet behind a locked door. A random check of four of the five pods revealed all tool inventory sheets were properly documenting tool usage including the staff name/initials and the time the tools were signed out and returned. During the review of the program's tools, all tools were found to be secured and inaccessible to youth.

Five youth were interviewed and all indicated they previously used scrub brushes. All youth indicated they had previously used mops/brooms. One of the five youth indicated they used screwdrivers and hammers respectively. Two of the five youth indicated they previously used yard rakes.

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's policies and procedures address youth use of tools. Staff supervise youth at all times when youth use mops, brooms, or scrub brushes during cleaning activities. Youth are only permitted to use the aforementioned tools or certain class A tools associated with program grounds maintenance after receiving an intake risk assessment. Risk assessments and reassessments are completed for each youth by the case managers and maintained in youth records. The risk assessment and reassessment include if youth are eligible to use tools.

Five interviewed staff reported the only tools youth are eligible to use are mops, brooms, and scrub brushes. Four staff reported youth could use scrub brushes and five staff reported youth could use mops and/or brooms.

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

The program's policies and procedures addresses protocols for outside contractors who perform work at the program. Documentation indicated a written notification and guidelines for outside contractors is signed by each contractor and inventory log is completed when outside contractors bring tools into the program. The inventory log is checked upon entry and exit to ensure the program and contractor can account for all tools utilized by outside contractors. During the annual compliance review, there were no outside contractors observed entering or exiting the program.

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.	

This specific procedures is outlined in the program's Department approved Continuity of Operations Plan (COOP). The program conducts practice drills in order to be prepared for immediate implementation or mobilization of the COOP whenever an emergency arises. The program conducts fire, safety, evacuation, program disturbances, and disaster drills. The documentation for drills includes the type of drill, date and time, participants, brief scenario, and findings to include recommendations. The program currently has three shifts. In the previous five months, the program completed fifteen fire drills and fifteen mock drills. Observation of fire evacuation routes and egress plans were posted throughout the program.

Five staff interviews reported they have participated in the weather, major disturbance, bomb threat, chemical spills, flooding, escape, and fire drills. Five interviewed youth reported they have been instructed on what to do in case of a fire. One youth reported fire drills are conducted monthly, one reported biweekly, one reported every three weeks, and one was not sure.

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

The program has a coordinated disaster plan and Continuity of Operations Plan (COOP). The plan provides 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 COOP is conspicuously posted in the program, readily available to staff, youth, and visitors, and disseminated to appropriate local authorities. The COOP plan is located in master control, the facility administrator's (FA) office, and the staff break room. The COOP is reviewed and

updated annually and was submitted to and signed by the Department's residential regional director/designee on May 06, 2019.

According to the FA, the COOP is accessible to all staff and is located in master control, the FA office, and the staff break room.

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 addressing the storage and inventory of flammable, poisonous, and toxic items and materials. The policy also addresses issuance and accessibility of the different chemical types based on their flammability, poisonous, or toxic items and materials. The policy addresses procedures for certain hazardous chemicals only handled by specifically identified personnel with proper training. All general cleaning chemicals for the kitchen and youth dorm were stored in separate secured closets with complete and accurate inventory sign-out sheets. All surplus cleaning chemicals for the kitchen and youth dorm were securely stored in a storage closet inaccessible to youth. All surplus chemicals were properly/accurately inventoried with proper documentation supporting the use of surplus as it was checked out or utilized. Each chemical contained Safety Data Sheets along with an individualized chemical inventory sheet. A review of the secured outside storage shed inaccessible to youth contained additional flammable chemicals, paints, oils, and miscellaneous chemicals.

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

The program's policies and procedures prohibit youth from handling flammable, poisonous, and toxic items. The program's facility plant manager is the only staff authorized to handle and dispose of flammable, poisonous, and toxic items. Procedures are in place for the supervision of youth who assist in cleaning activities requiring staff to maintain control of any cleaning agents used. Team observations and documentation reviewed found youth did not handle any toxic or cleaning items. A biohazard spill kit is stored in a secured area not accessible to youth and in the same area where the program deposits the bio-hazard waste in the bio-hazard waste bins.

Five interviewed youth indicated youth did not clean up blood, bodily fluids, chemicals, or bio-hazardous materials. Five youth indicated they assist with cleaning. Three youth stated staff handle all cleaning chemicals and the youth simply wipe down.

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

The program's policies and procedures address the disposal of flammable, poisonous, and toxic items. There were no incidents of chemical spills for the annual review period. Mop water and excess kitchen fluids are disposed in plumbing drains. The program does not purchase or use cooking grease for cooking purposes at any time.

An interview with the facility plant manager found chemical disposal practices were in accordance with disposal instructions listed on Material Safety Data Sheets (MSDS) or safety data sheets (SDS).

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

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

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

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

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

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

The program does not participate in any elements of water activities or swim test; therefore, this indicator rates as non-applicable.

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

The program has written established procedures by which the program may provide youth with opportunities to re-establish and maintain family and community ties to be involved in first person communications with attorneys and their agents, approved law enforcement, court and Department staff, and to ensure control of community access to the program. The program's activity schedule reflects visitation is held every Sunday from 2:30 p.m. to 5:30 p.m. Parent/guardians are mailed the program's procedure for visitation, mail, and phone usage upon the youth's admission to the program. The visitation log was available for review. The visitation log reflected the visitor's name whether they were an approved visitor, signature, time in and time out, identification check, rules provided, searched completed, and the initials of the staff completing the log. The written policy and procedures reflects only the facility administrator may approve special visits. Youth are allowed to make phone calls once a week and calls are facilitated by the youth's case manager. Observation of the phone call schedules were posted in each dorm. Phone calls begin after the youth are released from school. Phone calls are initially ten minutes for each youth but can increase with level achievement up to thirty minutes. Phone call logs were available for review and included the individual whom the youth was contacting, whether the call was successful, and the youth and staff initials. Youth are permitted to send and receive letters to those individuals on their approved correspondence list. All incoming and outgoing mail is searched by the youth's case manager.

Five interviewed youth reported they have been able to communicate with their families by mail, telephone, and letters.

5.23 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 does not participate in any controlled observation practice which would require search and inspection of the controlled observation rooms; therefore, this indicator rates as non-applicable.

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

The program does not participate in any controlled observations; therefore, this indicator rates as non-applicable.

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

The program does not participate in any controlled observation practice which would require safety checks and release procedures; therefore, this indicator rates as non-applicable.

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

The program has a written policy and procedures to identify stimuli which have both positive and negative effects on each youth in the program. The program maintains a youth safety plan binder which is located in master control. The program's safety plan includes warning signs, baseline behaviors gathered from collateral contacts and assessments, crisis recognition, jointly developed coping strategies, intervention strategies preferred by the youth, and a debriefing process. The program implemented a safety planning process for each youth in July 2019. Five youth safety plans were reviewed. Documentation reflected five youth had a safety plan. One youth did not have a safety plan developed within fourteen days of review. Documentation for the reviewed five safety plans reflected safety plans were jointly developed by using collateral contacts such as parent/guardians and previous assessments. Three of the five youth safety plans required updates or reviews. Two of the three applicable safety plans reflected one plan was missing two reviews/updates and one was missing one review/update. Two of the five plans were not applicable for a review or update.

Five interviewed youth reported they were involved in the development of their safety plan. Four of the five interviewed staff reported youth safety plans were located in master control and one staff was unsure. Three staff reported they review safety plans and two reported they were not sure of the review process.