STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

DOVE Academy

Twin Oaks Juvenile Development, Inc.
(Contract Provider)
5270 Ezell Rd.
Graceville, Florida 32440

Review Date(s): September 24-27, 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:

Jill Foy, Office of Program Accountability, Lead Reviewer (Standard 1)
Tara Frazier, Office of Program Accountability, Regional Monitor (Standard 4)
Lea Herring, Office of Program Accountability, Regional Monitor (Standard 3)
Fred Vrgora, Circuit One Probation, Juvenile Probation Officer Supervisor (Standard 5)
Jacqueline Woodham, Residential Services, Administrative Assistant II (Standard 2)

Program Name: DOVE Academy
Provider Name: Twin Oaks Juvenile Development, Inc.
Location: Jackson County / Circuit 14
Review Date(s): September 24-27, 2019

MQI Program Code: 1102
Contract Number: R2113
Number of Beds: 38
Lead Reviewer Code: 168

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 *	Satisfactory

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	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 *	Satisfactory
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	Non-Applicable
5.26	Safety Planning Process for Youth	Limited

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Program Overview

The Dove Vocational Academy is a thirty-eight-bed program, for fifteen to eighteen-year-old females, located in Graceville, Florida. The program is operated by Twin Oaks Juvenile Development Inc., through a contract with the Department. The program provides the following services: Mental Health Overlay Services (MHOS), Substance Abuse Treatment Overlay Services (SAOS), and vocational education services. In addition, youth participate in groups provided by the program to include Seven Challenges, Impact of Crime (IOC), Moral Reconation Therapy (MRT), and gender-specific programming. Additional treatment services provided includes individual, family, and group therapy, social and life skills trainings, restorative justice programming, and recreational therapy. Program administration is comprised of a program director and assistant program director. Case management services are provided by three case managers and one transition specialist. Mental health staff includes one designated mental health clinical authority (DMHCA) who is a licensed mental health counselor (LMHC), one psychiatrist, and three clinical coordinators. Medical services are offered Monday through Friday from 7:00 a.m. to 7:00 p.m., Saturday and Sunday from 8:00 a.m. to 6:00 p.m., and are provided by one medical doctor who serves as the designated health authority (DHA), one full time registered nurse (RN), one part-time RN, one full-time licensed practical nurse (LPN), and one part-time LPN. Educational services are provided by the Jackson County School Board. The layout of the program includes: seven total buildings; one houses the kitchen/cafeteria, clinical coordinator offices, and administration offices, one which houses medical, three which house five living units and case manager offices, one houses education, and one training building. The program has sixty-two operating security cameras providing coverage. At the time of the annual compliance review, the program had four vacant positions; three team leaders and one recreational therapist.

Strengths and Innovative Approaches

- The youth provided culinary services to a local church and accept culinary engagements in the community as needed, to include Department events at the Panhandle Area Education Consortium (PAEC), Marianna Garden Club Banquet, luncheons at the First Presbyterian Church of Marianna, and The Breast Cancer Symposium.

Standard 1: Management Accountability

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

The program has a written policy and procedures in place to ensure all staff and volunteers complete a background screening to ensure they are not a danger to the youth or the program's community. Eleven new staff members required a background screening since the last annual compliance review. Documentation reflected all eleven staff members received a background screening in which their criminal history was reviewed prior to their date of hire. None of the reviewed eleven staff required an exemption and one record indicated a break in service. Nine of the eleven reviewed staff members required a pre-employment assessment in which all nine applicable staff members received a passing score. There have been no new contracted staff hired since the last annual compliance review. The program submitted the Annual Affidavit of Compliance with Level 2 Screening Standards on January 10, 2019, meeting the annual requirement. Education staff are employed through the provider. Documentation was present in each of the personnel records reflecting the hiring authority reviewed the Department's Central Communications Center (CCC) involvement history, Staff Verification System, and Florida Department of Law Enforcement Automatic Training Management System prior to the date of hire.

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

The program has a written policy and procedures in place specific to five-year rescreening of employees. According to the written policy and procedures, a rescreening/resubmission is completed every five years from the date of original hire and at least ten business days prior to the five-year anniversary. Six staff members were eligible for a five-year rescreening since the last annual compliance review. Documentation in all reviewed personnel records reflected a five-year rescreening had been completed as required.

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

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

- *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 in place to ensure the program will provide an environment in which the youth, staff, and others will feel safe, secure and never threatened by any form of abuse or harassment. The program incorporates trauma responsive principles within the environment. Staff adhere to a code of conduct which can be found in the employee handbook. Staff sign and date the receipt of employee handbook and this document was observed in the personnel records. The Florida Abuse Hotline and the Department's Central Communications Center (CCC) was posted throughout the program. All youth are oriented on the procedures of how to access the Florida Abuse Hotline. A review of seven pre-service training records found staff received training on child abuse reporting. According to the written policy and procedures, youth will have immediate, unhindered access to report abuse. The shift supervisor and program director will be contacted in the event a youth reports abuse. A total of six incidents of alleged abuse have occurred since the last annual compliance review. Five incidents of alleged abuse were reviewed. There have been no substantiated allegations of abuse; however, two staff members received written reprimands; one for improper supervision and one for improper conduct. Seven of seven staff members interviewed were familiar with abuse reporting procedures. Six of seven staff members reported never observing a co-worker tell a youth they cannot call abuse; one reported they had. When questioned further, the staff member stated she has observed a con-worker trying to talk a youth out of making the call. This information was shared with the program director who emphasized the program's policy regarding the abuse procedures and stated youth are never denied the right to contact the Florida Abuse Hotline or CCC. Six of seven staff members reported they have never heard a co-worker using profanity when speaking to a youth. One staff member reported she had heard a co-worker use profanity, but it was not directed to the youth. Six of seven youth reported they feel safe in the program. One youth reported she did not feel safe due to bugs and snakes. Three of seven youth reported they have never been stopped from making an abuse call. Three

of seven youth reported they have never needed to make an abuse call. One youth reported she needed to make a call, but staff never came to get her to make a call. The interviewer asked the youth if she would like to make a call now in which she responded “no.” Six of seven youth reported staff are respectful when speaking to them; one youth reported sometimes staff “catch attitude.” Two of seven youth reported they have never heard staff use curse words when speaking with them; one reported once, three reported occasionally, and one reported often. Youth further reported staff were not directing curse words towards youth, nor were staff threatening youth. According to the program director, all staff are given a copy of the employee handbook to review and sign indicating their understanding of employee behavioral expectations. In addition, the program director indicated the program has a zero-tolerance policy for all staff regarding inappropriate treatment of youth in their care. The program director further reported all incidents are investigated and appropriate disciplinary actions will be taken if necessary. In addition, the program director was able to explain the program’s abuse reporting procedures.

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

The program has a written policy and procedures outlining management response to allegations of abuse. According to the written policy and procedures, the program director and leadership team at the program will take immediate action to address all incidents of physical and/or psychological abuse incidents of verbal intimidation, use of profanity and/or excessive force. Five incidents were reviewed in which two required disciplinary action by the program director. Both staff members received a written reprimand; one for improper supervision and one for improper conduct. Documentation reflected an internal investigation into the incidents was immediately initiated for all reviewed incidents. According to the program director, staff and youth are both instructed on the proper procedures regarding calls made to the Department’s Central Communications Center (CCC) and the Florida Abuse Hotline. In addition, calls are logged, tracked, and discussed in management team meetings. The program director reported no staff have received disciplinary actions due to substantiated allegations of abuse towards any youth.

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

The program has a written policy and procedures ensuring the program director and executive management will demonstrate the importance of monitoring incidents and alerting the Department’s Central Communications Center (CCC). The program had twelve CCC reports in the previous six months. This is a decrease in the number of incidents reported in the previous year. Five incidents were reviewed. All five CCC reports reflected they were reported within the required two-hour timeframe and were documented in the program’s logbook. There were no internal incidents/grievances which should have been reported to CCC. According to the program director, incidents are reported to the CCC within two hours and internal incident reports are completed.

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

The program has a written policy and procedures to ensure the use of physical intervention techniques are in accordance with the Florida Administrative Code and the least restrictive means of physical intervention is utilized based on the individual needs of each youth. The program had fourteen Protective Active Response (PAR) incidents within the previous six months. This is a decrease in the number of PARs reported in the previous annual compliance review report. The program's PAR rate during the annual compliance review period was 4.04, which is above the statewide Residential PAR rate of 1.59. Five PAR Incident Reports were reviewed. All five were completed by the end of the staff member's work day, included statements from all staff involved, did not require mechanical restraints, did not result in serious injury to youth or staff, and there were no instances in which youth alleged abuse. In each incident, the reports were reviewed and processed within seventy-two hours by the program director. Post-PAR interviews were conducted within thirty minutes of the incident in all five reviewed reports. The program director indicated all PAR incidents are reviewed by the program's PAR committee within twenty-four hours of the incident, discussing the cause of the incident and possible ways in which the situation could have been avoided. Additionally, the PAR incidents are tracked through Trendstat and discussed at management team meetings and on monthly Trendstat calls with the corporate office.

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

The program has a written policy and procedures ensuring all staff will receive required training within 180 days of employment. Seven personnel records were reviewed for completion of pre-service training. All seven staff records reviewed found each completed over 120 hours of training within 180 days. All staff members completed the required training prior to having any contact with youth to include: cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), ethics, suicide prevention, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), and active shooter. Contractual required training was completed and includes the following: Seven Challenges, Moral Recognition Therapy, Teen Relationships, Impact of Crime, homicidal risk, emotional behavioral development of adolescent youth, gender-specific programming, and trauma informed care. All instructors are qualified to deliver training. All pre-service training was observed documented in the Department's Learning Management System (SkillPro). The program submitted, in writing, a list of pre-service training to the Department's Office of Staff Development and Training on February 19, 2019 and the training plan was approved on February 20, 2019.

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

The program has a written policy and procedure in place to ensure the minimum training requirements of twenty-four hours outlines in the Department's policy and Florida Administrative Code are completed for all staff. Seven personnel records were reviewed for the completion of in-service training. Documentation reflected all staff completed the required twenty-four hours of annual in-service training to include: cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR) update, ethics, and suicide prevention. Although active shooter was not required, the training has been added to the program's in-service training plan for 2019 as a mandatory topic. Three staff members reviewed were applicable for annual supervisory in-service training. Each applicable staff completed the required training in the areas of management, leadership, personal accountability, employee relations, communication skills, and fiscal training. Additional contractual required training included: girls health/pregnant youth, Seven Challenges, Moral Recognition Therapy, Teen Relationships, Impact of Crime, homicidal risk, gender-specific programming, trauma informed care, and emotional behavioral development of adolescent youth. The program employees four nurses, all of which have a current certification in CPR with AED. All training was documented in the Department's Learning Management System (SkillPro). All instructors are qualified to deliver training provided. The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training on January 27, 2019 and was signed on January 22, 2019. The program has an annual in-service calendar, which is updated as changes occur.

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 ensuring youth are provided with a clear, accessible, and fair avenues for reporting and resolving complaints and grievances, allowing the opportunity to appeal decisions. A total of fourteen in-service and pre-service staff records were reviewed for grievance training and found all completed the required trainings. Upon admission to the program, the case manager reviews the program's grievance process as a part of the youth's orientation. Youth sign, initial, and date the orientation checklist which includes the grievance process topic. The program's grievance procedures include three phases: informal, formal, and appeal phases. The informal phase permits the youth to resolve the complaint or issue with the staff involved. This must be completed by the end of the staff's shift in which the grievance occurred. If not resolved, the grievance will then go to the formal phase. The formal phase requires the grievance to be submitted to the shift leader by the end of the shift in which the incident occurred. The shift leader will investigate the facts of the grievance and submit a decision within forty-eight hours of receiving the grievance. If the youth is not in agreement with

the decision, the grievance officer (assistant program director) will review the grievance with the staff and youth separately and issue a decision within forty-eight hours. The program director reviews and signs off on all grievances. Youth are allowed to ask for assistance at any time when completing a grievance form. Fifty-nine grievances have been filed since the last annual compliance review. Six grievances were reviewed and all were observed to be completed within the required time frames. Interviews with seven staff and seven youth confirmed all were familiar with the program's grievance procedures. The program director was interviewed and able to explain the program's grievance process.

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 program's contract of required services relating to delinquency interventions includes Impact of Crime (IOC) and Moral Reconation Therapy (MRT). Five staff have completed training on IOC and four staff members have completed MRT training. Five staff members have a bachelor's-level of education and four have a master's-level education. Education and work experience are considered by the program director when determining staff delivery of intervention services. The program's interventions are evidence-based and address the delinquency intervention strategy utilized. The daily activity schedule reflected the program is providing structured, planned programming or activities at least sixty percent of the youth's awake hours. Group sign-in sheets were available for review and reflected groups are being delivered as indicated on the group schedule. Six of seven youth records reviewed reflected youth received both IOC and MRT as a delinquency intervention. One of the seven youth has completed MRT and started IOC groups during the week of the annual compliance review. All reviewed youth records indicated each has been involved in a delinquency intervention addressing a priority need. All youth performance plans included a delinquency intervention. One youth's performance plan included MRT, but did not include IOC which the youth had participated in. According to the program director, staff who facilitate groups are required to possess at a minimum a bachelor's-level degree in a field related to counseling. Additionally, therapists are required to possess a master's-level education and staff are trained in the curriculum for which they will be facilitating groups. The program director confirmed youth are assigned to case managers and therapist based on their substance abuse or mental health diagnosis. In addition, the program director confirmed MRT and IOC are the curriculums currently being provided at the program.

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

The program provides life skills and gender responsive groups. Life skills and gender responsive groups address social skills interventions to include: communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking including problem solving and decision making. The program provides Moral Reconation Therapy (MRT) for all youth with a mental health diagnosis, Seven Challenges for

those with a substance abuse diagnosis, and all youth participate in gender-specific groups. A review of the activity schedule and sign-in sheets reflected groups are being held as required. A review of seven youth records indicated youth participated in life skills group. Interviews with seven youth confirmed they participated in various groups at the program. Six of seven youth were able to describe new skills they have learned and have practiced skills learned in group. One youth reported she has not learned life skills during groups and does not practice any skills learned in 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.	

According to the program's contract, Impact of Crime (IOC) curriculum is used to provide restorative justice awareness to youth. In addition, eligible youth participate in the Department of Transportation work program and community projects. The IOC curriculum is designed to assist youth to accepting responsibility for the harm they have caused others by their past criminal actions, challenge them to recognize and modify irresponsible thinking, and teach youth about the impact of crime has on victims, families, and communities. All IOC groups had at least one guest speaker during each cohort over the previous nine months. A review of staff training records reflected staff have been trained to facilitate these groups. The program's activity schedule reflects when restorative justice groups and activities are held. A review of seven youth records reviewed found all contained documentation of participation in restorative justice activities. A review of group sign-in sheet were available for review and reflected youth participated as required. According to the program director, over the past year, the youth in the program have logged over 400 community service hours, visited and crocheted blankets for Jackson County Senior citizens, and provided culinary services within the community.

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 designs gender-specific programming services based on the common characteristics of the primary target population. According to the program's contract, the following gender-specific programming services include Girl's in Real Life Situations, Teen Relationships, Girls Only, and Mean Girls. All gender-specific groups are provided on a rotating schedule as evidenced on the program's activity schedule. The curricula utilized by the program was available for review. Sign-sheets were reviewed and reflected groups are being held as indicated by the activity schedule. The program director reported the curriculum used is based on the Girls Matter Model, the curriculum enhances mental health services by addressing issues specific to female youth, including addiction/co-occurring disorders, depression, post-traumatic stress disorder (PTSD), and trauma caused by physical or sexual abuse. Additionally, the youth complete the PTSD workbook, Relaxation and Stress Workbook, parenting skills, and sexual education.

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

The program has a written policy and procedures in place ensuring an internal alert system is continually updated and communicated to all program staff sharing pertinent information concerning a youth's safety and security risks. According to the written policy and procedures, internal alerts are located in the shift supervisor's officer. When staff arrive for their shift, they review and sign the Alert Acknowledgment Form as well as the shift report from the previous shift. Documentation of this practice was observed during the annual compliance review. A posted food allergy alert roster was observed in the kitchen. Seven youth records were reviewed for alerts. Alerts were verified and updated by appropriate program staff upon the youth's admission to the program with one exception. A review of seven youth records found six were consistent with the program's internal alert roster. Two alerts for one youth reflected being open in the Department's Juvenile Justice Information System (JJIS); however, were not listed on the internal alert roster. The program determined the alerts were no longer applicable and were closed in JJIS during the annual compliance review. All other alerts reviewed were removed or updated by appropriate personnel. No other inconsistencies were observed. Seven interviewed staff reported alerts were reviewed daily and signed for. Staff reported alerts are located in the shift supervisor's office and can also be found on the shift reports. According to the program director, a pre-admission meeting is held prior to the youth's arrival to the program and alerts are discussed during weekly management 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 has a written policy and procedures ensuring all case records for the youth in the program provide all information necessary for effective case management and ongoing treatment. The program separates youth records into three separate records: individual healthcare record, individual mental health record, and an individual management record. The file tab on the individual management record contained the following information: youth's name, Department of Juvenile Justice identification number, date of birth, county of residence, and committing offense. The individual management record contained the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and a miscellaneous section. All youth records observed during the annual compliance review were labeled "Confidential." The program stores youth records in secure cabinets marked "Confidential" and youth do not have access to these areas.

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

The program has a written policy and procedures ensuring an opportunity for youth to be involved in decisions which impact them and the program community. In order to participate on the Dove advisory council, youth must: be on level Opportunity, Value, or Excel, display progress in all areas, have not been on restorative process, and have no refusals or removal from education for at least thirty consecutive days. According to the written policy and procedures, meetings are held quarterly or as needed with the program director. A review of the youth advisory council binder confirmed meeting minutes, sign-in sheets, and agendas were documented for the advisory council meetings. Documentation reflected the meetings were held quarterly as required. The program also utilizes Request to Speak forms which allows the youth to address concerns or make suggestions. The program also sends out Trauma Responsive and Care Environment (TRACE) surveys to youth twice a year. The most recent TRACE youth surveys were available for review (March 2019). A new round of surveys was requested by the program director on September 20, 2019. According to the program director, the results of the surveys are incorporated into an action plan for the program. The program director further reported the program tries to hold community meetings monthly or as needed. Seven interviewed youth reported they have participated in either an advisory council meeting, dorm meeting, or community meeting.

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

The program has a written policy and procedures stating the program director will ensure involvement with a Community Advisory Board and meetings will be held at least quarterly. The Community Advisory Board binder, which contained sign-in sheets, meeting minutes, agendas, and correspondence was available for review. Documentation reflected the meetings are being held quarterly. The program director solicits involvement from law enforcement, judiciary staff, community and business partners, school board or district, faith community, and victim services. There was no documentation to support the program director has solicited participation from a parent/guardian whose child was previously involved in the juvenile justice system since the last annual compliance review. A board member was available for interview by telephone and confirmed their membership and meeting frequency. According to the program director, the Community Advisory Board donates their time and expertise to help enhance program activities and assists with organizing community service projects.

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

The program has a written policy and procedures relating to program planning. According to the written policy and procedures, the program conducts quarterly staff meetings. Meeting minutes, agendas, and sign-in sheets reflected meetings are being held as outlined in the policy and procedures. Additionally, management meetings are held weekly and shift briefings are held daily. The program sends out Trauma Responsive and Care Environment (TRACE) surveys to both youth and staff twice a year. Based on the results of these surveys, the program will

develop a plan of action. The most recent (March 2019) surveys and plan of action was available for review. The program requested a new round of surveys to be completed on September 20, 2019. Twin Oaks Juvenile Development, Inc. completes Comprehensive Accountability Reports (CAR) on a quarterly basis and these reports are posted in the supervisor's office. The program maintains a suggestion box for staff to provide input or suggestions regarding the operations of the program. To minimize turnover and improve morale, the program awards staff for employee of the quarter and employee of the year. This includes a gift basket, plaque, gift card, cup, and a designated parking spot. The provider also offers a competitive benefits package. Seven staff were interviewed regarding communication at the program; two reported communication was very good, one reported good, one reported poor, and three reported communication was very poor. Staff further responded they can always give feedback, but feel their feedback is not considered. Six of seven staff reported they are not briefed on annual reports or surveys, one reported this information was posted in the shift supervisor's office. Six of seven staff reported meetings are held monthly and could identify topics discussed, two staff members reported it has been a couple of months since the last staff meeting. According to the program director, management meetings are held weekly and all staff meeting are held quarterly. The program director also reported any information which needs to be relayed to all staff is handled by the appropriate staff through emails to the shift leader with instructions. The program director added the CAR reports are posted in the shift supervisor's office and the program uses a data collection system call Trendstat to monitor positive and negative trends and performance measures. Additionally, the program director reported morale is not a real issue, the program has a staffing plan in place which includes a holdover list, staffing considerations, and unplanned absences.

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 ensuring a system is in place to evaluate staff on an annual basis in accordance with the program's performance standards and the employee standard of conduct. A sample position description was available for review. The sample position description reflected performance standards were clearly identified. Documentation reflected employee evaluations reflected performance evaluations are being completed on an annual basis. A review of the contract reflected all key positions are currently maintained except for the recreational therapist. The program's previous recreational therapist's employment ended on September 18, 2019 and the program is currently advertising this position. Seven staff members were interviewed regarding performance evaluations; one responded she has never had one, two responded yearly, two responded every six months, one has not been employed long enough to have one, one state she could not remember, and one stated every three or six months. A review of seven personnel records reflected staff have annual employee evaluations completed as required. According to the program director, staff receive an annual evaluation from their immediate supervisor, which contains individual goals and status of their completed goals, as well as reviewing their job description.

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

The program has a written policy and procedures in place ensuring youth will be provided opportunities to participate in recreational and leisure activities. These opportunities offer youth

a chance to acquire new skills, enhance existing skills, and develop competencies in areas such as relationship building, teamwork, and leadership. The program's activity schedule reflects a range of supervised and structured activities seven days a week. The program's contract reflects an agreement with the Boys and Girls Club of Tabula Rasa to provide a variety of activities such as crafts, recreations, and off-campus activities. The program's recreation therapist resigned on September 18, 2019. The program is currently advertising the position through an internet job posting site and the Chipola Workforce Center. The recreational therapist held a bachelor's-level degree in recreation therapy and was certified as a recreation therapist. All outdoor recreation activities are weather dependent and youth alerts are reviewed prior to activities to reduce the possibility of heat stress, dehydration, and other issues related to extreme outdoor temperatures. A review of the logbook reflected recreation and leisure activities are held in accordance with the daily activity schedule. Recreation was observed during the annual compliance review and was held as indicated on the activity schedule. Youth have a choice of recreation and leisure activities and are encouraged to explore their interests. A review of seven youth records reflected therapeutic activities are a part of the youth's performance plan. Youth input is obtained by youth Request to Speak forms, youth advisory council, and surveys. Seven interviewed staff reported youth participate in the following activities for approximately an hour: Zumba, yoga, exercise videos, board games, walk laps, kickball, basketball, volleyball, and relay races. Seven youth were interviewed regarding recreation activities provided at the program. Youth reported they participate in the following activities: exercise, basketball, obstacle course, volleyball, Zumba, walk laps, play board games, arts, and crafts. Additionally, youth reported how long they stay outside depends on the weather.

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.	

Seven youth records were reviewed for initial contact to parents/guardian upon admission to the program. A review of seven records found all contained documentation reflecting each youth's parent/guardian was notified by telephone on the day of admission to the program. In addition, each of the youth records included a letter to the parent/guardian within forty-eight hours of admission. All records included written notification to the court and juvenile probation officer within five days of 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.	

Seven youth records were reviewed to ensure youth are provided an orientation to the program. All seven records contained documentation of completion of orientation to the program on the day of admission. Upon completion of orientation, the youth and case manager sign and date an Orientation Checklist form. The program's orientation included the following topics: services available, daily schedule, expectations and responsibilities of youth, behavior management system, medical and mental health services, Florida Abuse Hotline, zero tolerance for sexual misconduct, contraband policy, performance planning, dress code/hygiene, visitation, mail, telephone use, transition/release process, community access, grievance procedures, emergency procedures, program tour, and assignment to a treatment team. Youth initial by each topic covered on the Orientation Checklist form acknowledging their understanding. A new admission to the program was observed during the annual compliance review. The case manager reviewed all of the aforementioned topics with the youth. Seven youth were interviewed regarding the orientation process. Six youth reported they received orientation to the program within twenty-four hours and one responded they did not.

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

The program obtains written consent for youth eighteen years or older, unless youth is incapacitated and has a court appointed guardian, before providing or discussing with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment. Seven youth records were reviewed for evidence of written consent of youth eighteen years or older. One of seven youth records were applicable for written consent. Written consent was observed in the youth record.

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

The program has a written policy and procedures addressing the classification of youth upon admission to the program. The written policy and procedures include a classification system which promotes safety and security, as well as effective delivery of treatment services based on determination of each youth's individual needs and risk factors. Seven youth records were reviewed for initial classification to the program upon admission. All youth records contained documentation of screening/assessment for classification as a part of the admission process. The initial classification process included all the required elements. A new Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) was completed on the day of admission for all seven youth reviewed. One of seven youth did not have her maturity level addressed on the initial classification form. Documentation of reassessments were observed in six of the seven youth records, one record did not contain a reassessment. The program has an internal alert which is posted in the supervisor's office and staff have copies of the internal alerts on the each living unit. According to the program director, a pre-admission planning meeting is completed by the treatment team members prior to the youth's arrival. The youth's current and past status is reviewed to determine the best possible placement, so the youth will thrive at the program.

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

The program has a written policy and procedures addressing gang identification. Seven youth records were reviewed for gang identification. One of seven youth records was applicable for gang identification. The program provided two additional examples of youth applicable for gang identification for review. For all three examples, law enforcement was notified both locally, in the youth's home county of residence, and the program documented the youth's gang identification in the Department's Juvenile Justice Information System. The program's education staff were notified of the youth's gang status. The youth's juvenile probation officer (JPO) was made aware of the youth's gang status for all three youth.

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

The program implements gang prevention and intervention strategies. Three applicable youth records were reviewed for gang prevention and intervention strategies. Each of the youth identified as a gang member or a gang affiliate, participate in Impact of Crimes groups weekly. In addition, a goal was observed on each of the youth's performance plan pertaining to gang interventions and strategies of gang prevention and intervention.

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

The program ensures an initial assessment of each youth is conducted within thirty days of admission. Documentation is maintained in the Department's Juvenile Justice Information System (JJIS) as required. The Department launched a new assessment tool titled Residential Assessment for Youth (RAY). The previous assessment tool utilized was the Residential Positive Achievement Change Tool (R-PACT). The Department communicated to contracted programs the RAY must be completed for each youth admitted to a program after April 8, 2019; however, the RAY was not available to the program for use until May 6, 2019. A review of seven youth records found six had a RAY completed within thirty days of admission. One youth's RAY was two days late due to the conversion period of the R-PACT and RAY. A review of seven youth records found four contained a RAY reassessment as required. One youth's RAY assessment was completed thirty days late. RAY reassessments were not due for two of the seven youth records reviewed. Reassessment documentation was maintained in each youth's record as required.

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

The program ensures a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission. A review of seven youth records found four contained documentation showing the YNAS was completed within thirty days of admission. One YNAS was completed two days late due to technical issues with the Department's Juvenile Justice Information System (JJIS) during a conversion period of the Residential Positive Achievement Change Tool (R-PACT) and the Residential Assessment for Youth (RAY). The Department communicated to contracted programs the RAY must be completed for each youth admitted to a program after April 8, 2019; however, the RAY was not available to the program for use until

May 6, 2019.Two of the seven records reviewed reflected the YNAS was completed three and four days late. All records reviewed reflected the YNAS was documented in JJIS as required.

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

The intervention and treatment team, including the youth, meet and develop the performance plan, based on the findings of the initial assessment of the youth, within thirty days of admission. A review of seven youth records found four contained documentation showing the Individualized Performance Plan (IPP) was developed within thirty days of admission. The Department launched a new assessment tool titled Residential Assessment for Youth (RAY). The previous assessment tool utilized was the Residential Positive Achievement Change Tool (R-PACT). The Department communicated to contracted programs the RAY must be completed for each youth admitted to a program after April 8, 2019; however, the RAY was not available to the program for use until May 6, 2019. One IPP was two days late due to technical issues with the Department's Juvenile Justice Information System (JJIS) during the conversion period. Two IPPs were completed two and four days late. All seven reviewed records contained IPPs which were developed after the RAY or the R-PACT. For each goal, the IPP specified the 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. All reviewed youth records contained documentation of the intervention and treatment team, to include: treatment leader, youth, administrative representative, living unit representative, treatment staff and educational staff, were present during the development of the IPP. All treatment team members signed the IPPs. Each of the IPPs contained the following elements: individualized goals, top three criminogenic needs, specific delinquency interventions, targeted court ordered sanctions (if applicable), transition activities, youth responsibilities, staff responsibilities, and goal completion target dates. One youth record was missing staff responsibilities. Within ten working days of completion of the IPP, the program sends a transmittal letter and a copy of the plan to the committing court, the youth's juvenile probation officer, the parent/guardian, and the Department of Children and Families counselor, if applicable. All records contained the applicable letters. Interviews with seven youth indicated participation in the development of their IPP, knowledge of their IPP goals, and each reported receiving a copy of their IPP.

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.	

A review of seven open and three closed youth records indicated performance reviews resulted in revisions to the youth's Individualized Performance Plan when determined necessary by the intervention and treatment team. In two of the reviewed records the Residential Assessment for Youth (RAY) indicated updates to the IPP were necessary; however, were not completed. A review of seven open and three closed records indicated one record did not have transition activities for the youth in the IPP when necessary.

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

A review of seven open and three closed youth records found completed Performance Summaries at ninety-day intervals with the exception of one closed record. In all records, Performance Summaries were prepared prior to the youth's release, discharge, or transfer from the program. As required, the Performance Summaries included youth's status on each goal, overall treatment progress, academic status, behavior, level of motivation/readiness to change, interaction with peers and staff, behavior adjustment to the program, significant positive and negative events, and justification for release discharge or transfer. Performance transmittals for all reviewed records included evidence youth could review, add comments prior to signing, and were provided a copy of summary, with the exception of one record which was not applicable. The original summaries were signed and dated by the treatment team leader, staff member preparing summary, program director and youth. In all open and closed records reviewed, copies of summaries were sent within ten working days to the committing court, juvenile probation officer, youth, and parent/guardian, with one exception, which was sent late. All records indicated release summaries were sent and signed as required except for two youth who are not yet eligible for release. Documentation confirmed victim notifications were sent in three applicable records. Exit assessments were completed on all three applicable youth reviewed, as well as parental notification of release. Additionally, the program provided copies of the performance summaries, transition plan, and any psychical reports completed to the juvenile probation officer (JPO) for applicable youth. Interviews with seven youth reported five received a copy of the performance summary sent to the court and two did not. None of the open or closed records reviewed were indicative of Sexually Violent Predator Program (SVPP) eligible youth.

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.	

A review of seven youth records indicated all parents/guardians were encouraged to be involved in the following case management processes: assessment, development of performance plan, progress reviews, formal treatment team meetings, and transition planning (parent/guardian attended by telephone if unable to attend in person). Two treatment team meetings were observed by during the annual compliance review. In each treatment team, the parents/guardians and juvenile probation officer were in attendance by telephone. The parents/guardians are notified about treatment team meetings by telephone. According to the program director, once a youth enters the program, the case manager contacts the parent/guardian through an introductory letter and phone call to advise them of the process regarding treatment teams. Interviews with seven youth confirmed parent/guardian participation 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.	

A review of seven youth records confirmed the treatment team members included the youth, representatives from the program's administration and residential living unit, education, treatment staff, nursing staff, recreation therapist, transition specialist, and a gang liaison if applicable. The following were invited and encouraged to attend through advanced verbal or written notification if attendance in person was not possible: juvenile probation officer, youth's parent/guardian, and representatives from the program.

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.	

A review of seven youth records found all Individualized Performance Plans (IPP) referenced or incorporated additional plans such as academic, performance, wellness, and safety. In addition, the IPPs referenced mental health and substance abuse needs. None of the records reviewed were applicable for a case plan through the Department of Children and Families or Agency for Persons with Disabilities.

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

A review of seven youth records found all formal performance reviews were held at least every thirty days and included youth's name, date of review, comments from treatment members, brief synopsis of youth's progress, performance plan revisions, progress on goals, positive and

negative behaviors, behaviors resulting in physical interventions, whether youth was provided an opportunity to demonstrate skills acquired in program, treatment progress, and Residential Assessment for Youth (RAY) reassessment results. All records indicated informal, biweekly treatment reviews were held and included the same information mentioned above. An observation of two treatment teams indicated all required staff were present (including education). The following information was discussed: youth's progress on performance goals, positive and negative behaviors, behaviors resulting in physical interventions, and treatment progress. All members actively participated in the meeting. The youth was provided an opportunity to demonstrate skills acquired in the program. Each youth's Individualized Performance Plan information was updated in the Department's Juvenile Justice Information System (JJIS). All seven interviewed youth answered favorably to being provided the opportunity during treatment team meetings to demonstrate skills learned in the program. All interviewed youth indicated staff review youth performance to include progress on performance plan goals, positive and negative behavior, and treatment progress.

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

Three closed youth records were reviewed for development and implementation of a vocational competency development program. All records contained a sample employment application, résumé, local Career Source Center information, documents essential to obtaining employment, and documentation the youth's parent/guardian is aware of the vocational plan. The program provides Type 2 career education programing services appropriate to the age, educational abilities and goals, as well as the length of stay and custody characteristics of the youth served. All three records indicated the vocational program was appropriate for the age of youth, appropriate for the educational abilities and goals of the youth, and appropriate for the length of stay and custody characteristics of the youth. All three closed records indicated career education programming included communication, interpersonal, and decision-making skills. An interview with the program director determined culinary arts and information systems are career education services offered to the youth. Interviews conducted with education staff support the following: two vocational classes are available, culinary arts and information systems. Upon completion of these courses' youth may earn and SafeStaff certificate or a Microsoft Office Specialist certificate. My Career Shines is the assessment administered. The youth also complete an entrance interview/questionnaire and education transition plan.

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 integrates education instruction into their daily schedule in such a way as to ensure the integrity of required instructional time. Youth participate in educational and career-related programs for 250 days distributed over twelve months with a minimum of twenty-five hours weekly of instruction. Youth receive credits for educational and training experience. The activity schedule and logbook document minimal interference of educational instruction. A review of the logbook of six randomly selected days reflected youth are attending education according to the schedule. Interviews with seven youth indicated four stated there are minimal interruptions and three reported there were a lot of interruptions. The lead teacher reported the

program's instructional schedule is Monday through Friday 7:45 a.m. to 10:25 a.m. and 12:25 p.m. to 3:05 p.m.

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.	

A review of three closed youth records found each has an individual education transition plan developed based on youth's post-release goals, beginning at admission. Key personnel included were youth's parent/guardian, education staff, residential staff, post-release school district, guidance personnel, and personnel in the district with access to management information system. The transition plans addressed services and intervention based on these elements: youth's assessed educational needs and post-release education plans; education based on individual needs and performance; and specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services. In all three closed records, transition plans included: provision for continuation of education and/or employment, completed employment application, résumé, valid State of Florida identification card, local Career Source Center information, documents essential to obtaining employment, and evidence the youth's parent/guardian was aware of the plan.

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

Three closed youth records were reviewed to verify transition planning. All records indicated a transition conference was held at least sixty days prior to targeted release date. Treatment team members included youth, treatment team leader, program director or designee, and any other necessary members. All records contained evidence the youth's juvenile probation officer (JPO), youth's parent/guardian, education staff, and other pertinent parties were invited to attend. During the transition conference, participants reviewed transition activities on youth's performance plan, revised performance plans if necessary, identified additional transition activities if needed, identified target completion dates, identified persons responsible for completion, as well as signatures and dates were obtained to acknowledge transition goals and accountability for completion. According to documentation reviewed, everyone with an assigned responsibility in the transition plan for each youth was in attendance; therefore, a copy of the plan was not sent out. In two out of three records where a Community Re-Entry Team (CRT) meeting occurred, the meeting was conducted prior to the youth's release, with youth and case

manager participation. There was documentation the intervention and treatment team leader invited and encouraged participation of all pertinent parties through advanced notification of the CRT.

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 closed youth records found all included exit portfolios which were discussed and verified at the exit conference. Each of the three exit portfolios contained all required items. The exit portfolio was completed and provided to the youth upon their release from the program. The program staff forwarded the exit portfolio information to the juvenile probation officer and documented this in the youth's case management record. The provider's contract was reviewed and reflected they are meeting all requirements, in addition to administrative rule requirements.

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

A review of three closed youth records found all indicated exit conferences were conducted at least fourteen days prior to the youth's release and included the following criteria: conference was conducted after the program notified the juvenile probation officer (JPO) of the release; documentation in the youth record included the date, signature and summary pending transition goals; and, the status of transition activities established at the transition conference were reviewed and plans for youth's release were finalized. In all records, the date of admission and date of termination documented in the case record correlate with the Department's Juvenile Justice Information System (JJIS). Three of three reviewed records reflected the required attendees were present: program director or designee, treatment team leader, and youth. Additional attendees included the youth's JPO and therapist. An education representative did not attend any of the exit conferences as there was no new or additional education information to add. Two of three parents/guardians were invited but were unable to participate by telephone or in person. Three out of three records indicated Exit Conferences were separate from the transition and Community Re-entry Team meetings.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor (LMHC), who serves as the designated mental health clinician authority (DMHCA), with the position title of clinical services director, licensed under Chapter 491, Florida Statutes. A review of the license through the Florida Department of Health, reveals it is clear and active in the State of Florida expiring on March 31, 2021. The DMHCA is employed full-time and is on-site forty hours a week, five days a week, and as needed on the weekends. A copy of the license and position description was available on-site. Licensure and position descriptions are readily available on-site for all mental health and substance abuse staff at the program.

An interview was conducted with the DMHCA and reported all mental health and substance abuse services are provided by or under the direct supervision of the DMHCA who is responsible for the oversite and the delivery of all treatment related services at the program. The DMCHA ensures there is appropriate coordination and implementation of mental health and substance abuse services.

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 does not have any other licensed clinical staff other than the designated mental health clinician authority; therefore, this indicator rates as non-applicable.

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 three clinical coordinators with master's-level degrees from an accredited college in the field of counseling, social work, psychology, or related human services field. Two of the clinical coordinators have a master's-level degree in psychology and the other clinical

coordinator has a master's-level degree in marriage and family counseling. A copy of each master's-level degree was provided and in compliance with the Department's Rule 63N-1. The designated mental health clinician authority (DMHCA) meets with the clinical coordinators for direct group supervision of one hour, face-to-face, once a week. All documentation was provided on a form similar to the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. This supervision includes a review of the samples of the clinical coordinators caseload, provision of the directives/instructions, and recommendations for continued service provision. The clinical coordinators provide mental health and substance abuse services in the program as an employee of a service provider licensed under Chapter 397, Florida Statutes. The staff work under the direct supervision of a qualified professional as defined in section Chapter 397.311, Florida Statutes, who is the DMHCA. All non-licensed mental health and substance abuse clinical staff at the program providing services have received training in accordance with the Department's Rule 65D-30 Florida Administrative Code. Each non-licensed mental health clinical coordinator received twenty-hours of training in Assessment of Suicide Risk (ASR), to include five ASRs or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and documented on the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. One non-licensed clinical staff is a registered mental health counselor intern with an expiration date of September 25, 2022, which was provided and reviewed. The DMHCA is responsible for reviewing and signing comprehensive substance abuse evaluations, updated comprehensive substance abuse evaluations, initial substance abuse treatment plans, and individualized substance abuse treatment plans prepared by the clinical coordinators within ten calendar days. The DMHCA is responsible for reviewing each ASR and follow-up ASR, crisis assessment, and follow-up crisis assessment within twenty-four hours of the referral for assessment. The form must be signed by the DMHCA the next scheduled time on-site.

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

The program has written Facility Operating Procedures (FOP) addressing the implementation of a standardized admission and intake mental health and substance abuse screening process. The standardized screening process includes a review of commitment packet information, and administration of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) in the Department's Juvenile Justice Information System (JJIS). Seven youth records were reviewed and all had a MAYSI-2 screening conducted by a trained staff on the day of the youth's arrival to the program in a confidential manner and completed in the Department's JJIS. Documentation in all seven reviewed records provided evidence the screener considered all available information, commitment packet, reports, and records for existing mental health and/or substance abuse disorders. The program's policy and procedures require youth be referred for further evaluation on the MAYSI-2, which was confirmed in all records. All reviewed records included an override on the MAYSI-2, which resulted a request for further assessment, regardless of whether the youth met the criteria for further assessment. The program's policy and procedures require all youth receive an Assessment of Suicide Risk (ASR) within twenty-four hours of admission. All records included an ASR for each youth within twenty-four hours of admission. The program director and designated mental health clinician authority (DMHCA) were notified, consulted, and approved by clinical staff completing the ASR. Two of the seven

records were of youth admitted to the program with a suicide risk alert. Interview with the DMHCA reported youth coming from detention rarely notify the program when a youth is on Precautionary Observation (PO) supervision, so the program is not always aware of the youth's supervision status when entering the program. The program was in the process of implementing a system to check and verify all open alerts of youth upon admission. After further review, one of the two youth's alerts had been improperly closed by the detention center. Each youth immediately reports to medical for intake to the program and are under the constant supervision of medical clinical staff, until the youth reports to mental health clinical staff for assessments. Medical and mental health clinical staff are not required to keep a PO log for youth at intake when the youth is under constant supervision. The program's policy and procedures require all youth receive a referral for a comprehensive evaluation, which was completed on the day of admission and included in all seven records. All seven youth records contained a Clinical Substance Abuse Admission Screening, which was completed for each youth in addition to the MASYI-2.

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.	

A review of seven youth records each contained a new Comprehensive Mental Health Evaluation completed within thirty calendar days of admission. All seven records were reviewed and signed by the designated mental health clinician authority (DMHCA) within ten calendar days after the evaluation was conducted. In all reviewed records, the evaluation included the demographics, a reason for the evaluation, home environment, history of physical and/or sexual abuse, neglect, witnessing violence, mental health, substance abuse, behavioral observations, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression, and recommendation. In all seven records, a new substance abuse assessment was completed by the clinical coordinator, then reviewed and signed by the DMHCA within ten calendar days after the evaluation was conducted. All records had consent forms signed by the youth for substance abuse services. In all reviewed records indicated the evaluation included a reason for the assessment, home environment, history of physical and/or sexual abuse, neglect, witnessing violence, mental health, substance abuse, behavioral observations, methods of assessment, patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, risk factors of continued alcohol and other drug abuse, clinical impression including Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, and recommendations.

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.*	

A review of seven youth records found all were assigned to a treatment team comprised of the youth, program's administration, residential living unit representative, and other staff responsible

for delinquency interventions; upon arrival to the program. Treatment teams have representatives from administration, education, vocational training, medical staff, mental health staff, substance abuse staff, youth, and the parent/guardian, if possible. All reviewed records indicated each youth was receiving treatment with individual, group, or family counseling provided by a qualified professional in accordance with the youth's initial and individualized treatment plans. All youth records had current Authority to Evaluate and Treatment (AET) form. All youth records had the Department's Youth Consent for Substance Abuse Treatment and Youth Consent for Release of Substance Abuse Treatment Records forms with mental health and substance abuse documented diagnosis. All mental health and substance abuse treatment notes were documented on a form similar to the Department's Counseling/Therapy Progress Notes in all records. Group therapy is limited to ten or fewer youth for mental health treatment groups and fifteen or fewer youth for substance abuse treatment groups at the program. All youth participated in individual psychotherapy or counseling, as well as psychosocial skills training designed to address specific skill deficits. The clinical coordinators conduct the substance abuse groups under the supervision of the designated mental health clinician authority.

Seven youth were interviewed to determine if they were participating in groups and receiving any specialized therapies, which all replied yes. Seven direct care staff were asked if they facilitate mental health groups and all replied no.

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.*	

A review of seven youth records found all Initial Treatment Plans were developed on the youth's date of arrival. The Initial Treatment Plans were signed by the clinical coordinator and youth upon admission, and the designated mental health clinician authority (DMHCA) within ten calendar days. The Initial Mental Health and Substance Abuse Treatment Plan was documented on a form similar to the Department's Initial Mental Health/Substance Abuse Treatment Plan form which included the youth's psychiatric needs. All records contained an Individualized Treatment Plan completed within thirty days of admission and on a document similar to the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. The clinical coordinators develop the Individualized Treatment Plans under the direct supervision of the DMHCA. The DMHCA's signed the Individualized Treatment Plan within ten days of completion in six of the seven records reviewed. The remaining youth record was signed by the DMHCA twenty days after completion. All seven records included signatures from participating treatment team members, including a parent/guardian note indicating participation by telephone. All seven Individualized Treatment Plans included psychiatric services, including the initial psychiatric evaluation all youth received. The name of the medication and frequency of monitoring by the psychiatrist of the youth were included on the Individualized Treatment Plans for youth taking medications. All seven Individualized Treatment Plans documented what

services the youth is to receive and how often the youth will attend those services. Individualized Treatment Plan reviews were conducted every thirty days on a form similar to the Department's Individualized Mental Health Treatment Plan Review form.

Three closed records were reviewed for Discharge Plans. All three records had a Discharge Plan documented on the Department's Mental Health/Substance Abuse Treatment Discharge Plan form. All three discharge summaries included the services needed for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by the youth. The Discharge Plans were discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conferences in two of the three records. The remaining closed record was a youth who was eighteen years of age and direct discharged, therefore, parent/guardian and JPO participation was not required. The program provided a copy of the Mental Health/Substance Abuse Treatment Discharge Summary to the youth for all three records and the parent/guardian and JPO in two applicable records.

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 Mental Health Overlay Services (MHOS) to fourteen slots and Substance Abuse Treatment Overlay Services (SAOS) to twenty-four slots. The program is licensed in accordance with Chapter 397, Florida Statutes to provide substance abuse services which expires July 8, 2020. Treatment groups provided to youth at the program include Seven Challenges, Moral Recognition Therapy (MRT), Anger Control, Seeking Safety, and gender-specific programming.

Interview with the program director indicated the program is designated to provide SAOS and MHOS to youth as their specialized treatment services. The program demonstrates specialized treatment services are provided in accordance with Florida Statute, Administrative Rule, Department's contract, and according to the Department of Juvenile Justice Mental Health and Substance Abuse Manual. The Dove Vocational Academy mental health and substance abuse model is based on cognitive behavioral therapy. Cognitive-behavioral therapy combines the individual goals of cognitive therapy and behavioral therapy. In this model, the therapists attempt to make the youth aware of these distorted thinking patterns, and/or cognitive distortions, and assist them with change. Cognitive behavioral therapy integrates the cognitive restructuring approach of cognitive therapy with the behavioral modification techniques of behavioral therapy. The therapist works with the youth to identify both the thoughts and behaviors which are causing distress, and to change those thoughts in order to readjust the behavior. In some cases, the youth may have certain fundamental core beliefs, which are flawed and require modification. By showing the youth others value her, the therapist both exposes the irrationality of the youth's belief and provides her with a new model of thought to change old behavior patterns.

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

The program has a written policy and procedures to provide psychiatric services to the youth they serve. These services are provided by a fully licensed, board certified psychiatrist with certification in child and adolescent psychiatry with the American Board of Psychiatry meeting the requirements of Rule 63N-1, Florida Administrative Code. All youth entering the program receive an initial psychiatric evaluation within fourteen days which is in compliance with Rule 63N-1.0085, Florida Administrative Code. Three of the seven youth did not have a history of prescribed psychotropic medications. Four youth entered the program with a medication prescription, but two youth were not currently taking the prescription medication at the time of admission. The initial diagnostic interview included the youth's medical, mental health, and substance abuse history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders-IV-TR diagnosis, and treatment recommendation in all seven records. Four of the youth were prescribed medication and the records contained page three of the Clinical Psychotropic Progress Note (CPPN) explaining the need for the medication related to the youth's diagnosis, target symptoms, potential side effects, risks and benefits of taking the medication, and frequency of medication monitoring/management. All four youth taking prescribed psychotropic medication were seen for a medication review by the psychiatrist, at a minimum of, every thirty days. Two of the four applicable youth were initially prescribed psychotropic medication or had a change to an existing psychotropic medication regimen. All four applicable youth had page three of the CPPN completed with the psychiatric review within every thirty days, as specified in Rule 63N-1 Florida Administrative Code.

The program does not employ or contract a psychiatric advanced practice registered nurse (APRN)/advanced registered nurse practitioner (ARNP). According to the provider's contract, the psychiatrist is on-site for a minimum of one day a week for two hours each visit and is available for emergency consultation twenty-four hours a day, seven days a week. The program was not able to provide a sign-in log for the psychiatrist; however, the psychiatrist visit was verified by the number and dates of the youth's psychiatric reviews. The psychiatrist's evaluation and recommendations are incorporated into the youth's mental health or substance abuse treatment plan. The psychiatrist has ultimate responsibility for the prescription and monitoring of psychotropic medications in the program, as well as actively participates in, manages and supervises psychotropic medication services.

An interview with the psychiatrist confirmed he is notified at admission if any youth is on psychotropic medications and approves the orders to be continued until an initial psychiatric assessment is completed on the next weekly visit.

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

The program maintains a written suicide prevention plan. According to the Department's Learning Management System (SkillPro), all seven pre-service and seven in-service staff received the required six hours of annual suicide training, two hours of web-based training and four hours of instructor-led training. The program's suicide prevention plan identifies and assesses the youth at risk of suicide, staff training, suicide precautions, levels of supervision, referrals, communication, documentation, immediate staff response, and the review process. The suicide prevention plan is reviewed annually by the program or as-needed. The program's suicide prevention plan was updated during the annual compliance review and signed by the program director and designated mental health clinician authority.

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

The program has a written policy and procedures in place for suicide prevention services which requires all youth participate in an Assessment of Suicide Risk (ASR). All seven youth received an ASR on the day of admission. A review of seven youth records found two were admitted to the program with previous suicide risk alerts. One youth's suicide risk alert was incorrectly closed by detention before transport to the program. All seven youth received an ASR at admission, were not found to be a suicide risk, and were placed on standard supervision. The ASR was completed using the Department's ASR form. One youth record was of a youth admitted with open suicide risk alerts from detention, but the program was unaware of the youth Precautionary Observation (PO) supervision level. Therefore, the youth's ASR did not properly document the step-down supervision from constant sight and sound to standard supervision. Also, there was no documentation the youth's parent/guardian and juvenile probation officer (JPO) being notified, regarding the youth's potential suicide risk. All seven records contained an ASR completed by qualified staff with the result properly documented on the ASR form. The one youth with an open suicide risk alert was not closed immediately upon the youth being placed on standard supervision. All ASRs reviewed included the program director and designated mental health clinician authority signatures, confirming their notification, consultation, and approval the ASR result. The Suicide Precaution Observation Logs reviewed included "safe housing areas" and did not limit a youth's activity to an individual room or restrict the youth to a sleeping room. The program logbook was reviewed and noted the two incidents of a youth placed and released from PO.

The program does not have a Secure Observation room. The program keeps suicide response kits on all five dorms and in the administration building. The program has an established review process for every serious suicide attempt which includes: circumstances surrounding the event, program procedures relevant to the incident, staff training, medical and mental health services involving the victim, possible precipitating factors, and recommendations for changes, if necessary.

Seven staff interviewed were asked what actions they would take if a youth verbalized they were suicidal. All staff responded constant sight and sound supervision for the youth and to document supervision. Six staff reported to notify mental health. Five staff reported to notify the supervisor. Seven staff were asked where the suicide kits were kept and six reported on the dorm, two staff reported in the supervisor's office, and one staff did not know where the suicide kits were located.

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.	

A review of seven youth records found one was applicable for Suicide Precaution Observation Logs. The Suicide Precaution Observation Logs were maintained for the duration the youth was placed on suicide precautions. The appropriate level of supervision was documented, all observations of the youth's behavior was documented in real time and did not exceed thirty minutes. Warning signs, which would require notification to the program director or designated mental health clinician authority (DMHCA) were documented on all constant sight and sound Suicide Precaution Observation Logs. The Suicide Precaution Observation Logs are reviewed and signed by the shift supervisor and DMHCA. All supervision, supervisory reviews, and safe housing requirements were met in all constant sight and sound supervision logs. An informal interview with two youth who have been on suicide precautions confirmed staff were always with them and they were never left alone 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.	

A review of the medical and mental health drills revealed mock suicide drills were conducted at least quarterly on each shift. The program's mock suicide drill included action taken by staff including methods for contacting other program staff by radio or calling for back-up medical support and 9-1-1, as well as provisions of life saving measures, such as cardiopulmonary resuscitation (CPR) and use of the suicide response kit. All staff with direct contact on a day-to-day basis with youth participated in the mock suicide quarterly drills, meeting the annual requirement. The program director reported there are four shifts and all shifts are required to conduct drills. A drill calendar is posted, and it includes mock suicide drills and self-inflicted injuries. These are conducted no less than quarterly for each shift. Interview with the program director confirms there are four shifts, and all are required to conduct drills. The program director also reports the program has a drill calendar posted which includes mock suicide drills and these drills are conducted no less than quarterly for 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 written policy and procedures in place to respond to youth in crisis. If a youth is having a mental health and/or substance abuse crisis, the emergency plan includes notification and alert system, means of referral to include youth self-referral, communication, supervision, 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.	

The program reported no identified youth as having a crisis assessment during the annual compliance review period. A review of staff training records, the program's policy, and the program's crisis assessment tools were reviewed and found no issues with the program's process.

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 written policy and procedures in place to respond to youth in crisis. If a youth is having a mental health and/or substance abuse crisis, the emergency plan dictates immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for mental health evaluation and treatment under Chapter 394 Florida Statutes (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397 Florida Statutes (Marchman Act), documentation, training, and review. The program utilizes Emerald Coast Behavioral Hospital in Panama City, Florida for any youth transported for Baker Act or Marchman Act procedures.

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

One youth record was applicable for Baker Act services. During the first Baker Act incident, staff immediately contacted the shift supervisor and placed the youth on one-to-one supervision. The program director, assistant program director, designated mental health clinician authority (DMHCA), and nurse were all notified. Once the youth was determined to be an imminent danger to self, the local sheriffs department transported the youth to the nearest receiving facility. The youth returned to the program and was placed on constant supervision upon return. A mental health referral was completed indicating a Mental Status Examination and Assessment of Suicide Risk was completed by a qualified clinical staff. The youth was maintained on a constant supervision level until properly transitioned to a lower level of supervision, which was consulted and approved by the program director and DMHCA.

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 currently contracts one medical doctor, who serves as the program's designated health authority (DHA), who specializes in Family Practice and holds an unrestricted license which meets all requirements for independent and unsupervised practice in the State of Florida. This license expires on January 31, 2021. The DHA is on-call twenty-four hours a day, seven days a week, and on-site every Thursday for the time needed to provide medical consults to youth, as verified through the physician sign-in sheets. At the time of the annual compliance review, the DHA does not designate another physician for coverage in his absence. Healthcare personnel explained the DHA will re-arrange his schedule to continue to meet his weekly on-site visits, and if he is out of town he continues to answer his phone twenty-four hours a day, seven days a week. The DHA was interviewed to describe their role at the program. He indicated as the medical director he conducts comprehensive physical assessments, follow-up on any referred sick calls, conducts monthly examinations on pregnant youth, as well as other medical duties. The DHA stated he communicates with the program staff regarding each youth's medical needs by having a nurse present during each exam of a youth to discuss all orders verbally and ensure proper documentation. The DHA stated all youth information is placed in the DHA's box, including labs, episodic incidents, sick calls, and off-site referral forms to ensure information is reviewed and documented appropriately. The DHA added all sick calls, episodic incidents, and labs are reviewed by the registered nurse, who notifies the DHA of any adverse findings by phone. Findings with normal limits are placed in the DHA box for review at the next scheduled site visit.

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

The designated health authority (DHA) and program director signed and dated all respective treatment protocols and Facility Operating Procedures (FOP) to address health-related procedures. A cover page is at the beginning of the FOP and treatment protocol binder, where all nursing staff have signed and dated they have reviewed the material. This review occurs annually, with the last one occurring on August 30, 2019. The program's registered nurse provided documentation of the newly employed health care personnel's comprehensive clinical orientation to the Department's healthcare policies and procedures. All treatment protocols were written and authorized by the DHA. The psychiatrist reviewed the FOP's on August 1, 2019 related to psychiatric services and psychotropic medication management.

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

A review of seven youth records found all contained a copy of the Authority for Evaluation and Treatment (AET), with the word "copy" stamped in red. The AET is valid for as long as the youth is under any type of supervision with the Department. Copies of the parental notifications are

maintained behind the AET in all seven Individual Healthcare Records (IHCR). The registered nurse (RN) was interviewed to determine the program's policy for obtaining a new or current AET. The RN indicated if a current AET is not in the Department's Juvenile Justice Information System (JJIS) or sent in with the youth, medical staff would contact the juvenile probation officer for assistance in obtaining a newly signed AET from the parent/guardian. The RN stated the program is no longer required to obtain AETs for youth who turn eighteen while in the program.

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.	

The program has a policy and procedures in place to inform the parent/guardian of significant changes in the youth's condition and/or obtain consent for new medication and/or treatment, if prescribed. A review of seven youth records found all had documentation of parental notification for over-the-counter (OTC) medications, as well as vaccinations/immunizations beyond those covered by the Authority for Evaluation and Treatment (AET). One of the seven records were applicable for notification made by telephone and, subsequently, in writing, for an off-site emergency care, but neither of those notifications were made. A review of seven youth records found four were applicable for youth taken off-site for routine medical treatment, and all had a written Parental Notification of Health-Related Care form in their records which addressed off-site routine visits mailed to the parents/guardians upon admission. A review of seven records found five were applicable for verbal attempts, as well as written notifications, made to the youth's parents/guardians and documented in the progress notes for new medication. All five verbal attempts were witnessed by a second staff member and initialed by the staff. A review of seven youth records found four had youth initially prescribed a psychotropic medication, discontinued, or had a change in medication dosage. All four records had documentation on page three of the Clinical Psychotropic Progress Note (CPPN) of notification or attempted notification of the parent/guardian. All four records had documentation of page three of the CPPN was sent through certified mailed to the youth's parents/guardians; however, none were returned to the program. A review of seven youth records found all had vaccinations verified within thirty days of admission. One youth record was applicable for receiving parental consent prior to administering a vaccination and found to be compliance. Medical staff personnel utilize the Florida Shots website to obtain a copy of the youth's shot records if it is not available, which occurs during the intake process. Interview with the registered nurse regarding the process for documenting parental exemption from immunizations confirmed the parent/guardian must complete the Religious Exemption from Immunization form provided by the County Health Department, which is signed and authorized there, and submitted to the program.

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

A review of seven youth records found all had the Facility Entry Physical Health Screening form (FEPHS) completed on the date of admission by either a registered nurse (RN) or licensed practical nurse (LPN). Only one youth record was applicable for a physical change in custody since the youth's arrival to the program and a new FEPHS was completed upon the youth's return. Upon admission, all reviewed youth records confirmed each consented for a pregnancy test.

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

A review of seven youth Individual Healthcare Records (IHCR) indicated all youth received general care orientation upon admission to the program. The orientation included access to medical care, sick call, what constitutes an "emergency" and when to notify staff, medication process to include side effect monitoring, the right to refuse and how it is documented, what to do in case of a sexual assault, or attempt, and the non-disciplinary role of the health care providers. Each youth signed the orientation packet indicating a review was conducted in conjunction with medical personnel. A copy of the Health Care Contacts was reviewed for accuracy and posted in the medical area.

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

A review of seven youth records found three were applicable for referral to the designated health authority (DHA). All youth records had evidence of a referral to the DHA, one by telephone and the remaining two were written referrals. One youth is pregnant, and the other two youth have a body mass index (BMI) over twenty-five. None of the three records were identified as in-need of an emergency. Notification of the referral was documented in the youth's chronological progress notes for all three records. All three youth records were documented on the Chronic Condition Log.

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

Seven Individual Healthcare Records (IHCR) were reviewed and all had a new Health-Related History (HRH) form completed on the date of the youth's admission by a licensed nurse. All seven IHCR indicate the HRH was reviewed by checking the box on the Comprehensive Physical Assessment (CPA) form and by the designated health authority (DHA) signature on the HRH. All seven IHCR had the HRH completed prior to the CPA. The registered nurse was interviewed to determine who is responsible for completing the HRH and what is the timeframe for its completion, and indicated medical staff complete the HRH immediately upon youth's admission.

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

The program utilizes the Department's Comprehensive Physical Assessment (CPA) form in all seven records, which is in accordance with 63M-2.0044. Seven out of the seven Individual Healthcare Records (IHCR) had a current CPA on file upon admission, however, the program completes a new CPA by the designated health authority (DHA) for all new youth within seven days of admission. All seven CPAs documented a medical grade. Any gynecological

examination will be referred off-site as needed. All seven new CPAs were reviewed as the youth were examined and signed off as reviewed by the DHA. All reviewed youth records indicate all sections of the CPA are marked with an “O” or an “X”, or “deferred” with the youth’s signature, as well as the signature of the DHA. A refusal form was completed and filed in all seven IHCR. The Department’s Problem List form was completed, updated, and filed in each IHCR for all reviewed youth records. Each record had at least one verified tuberculosis test (TST) within the last year documented on the CPA and Infectious and Communicable Diseases (ICD) forms in each IHCR. The Facility Operating Procedures (FOPs) are in compliance with the Centers for Disease Control and Prevention new 2006 recommendations and Occupational Safety and Health Administration (OSHA) Standards. Interview with the registered nurse (RN) confirmed TST screenings are completed annually and on an as needed basis (if symptomatic). The nurse also reports all youth are sent to the County Health Department for testing.

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 policy and procedures in place to ensure all youth who enter the program are evaluated and treated, if necessary for sexually transmitted infections (STIs). A review of seven youth records found five were applicable for youth who were screened and evaluated for STIs. All applicable youth were referred to the designated health authority (DHA) for further evaluation, resulting in youth receiving testing. All five youth records had test results documented on the Infectious and Communicable Diseases (ICD) forms, excluding Human Immunodeficiency Virus (HIV) results. All five youth records had referrals and testing documented in the progress notes. A review of seven youth records found three were applicable for youth who received HIV testing. All three Individual Healthcare Records (IHCR) contained documentation the youth was offered counseling, testing, and treatment for HIV by a certified HIV counselor. All three IHCRs had documentation of the youth’s consent for the HIV testing, as well as pre/post-test counseling through the Bay County Health Department. All three youth records had their HIV test results filed in a confidential manner consistent with F.S. 381.004, located a sealed envelope with the word “confidential” stamped on it, and filed in each IHCR. According to medical personnel, the program never includes the youth’s HIV status in the internal alert system. The program is consistent with Chapter 381 F.S., HIV test results can be disclosed only to the youth, the youth’s legal authorized representative, health care providers during the course of consultation, diagnosis or treatment of the individual, the Department of Health for purposes of reporting and control of spread of disease, health program staff committees conducting program monitoring, evaluation, and service reviews, medical personnel who have been subject to a significant exposure, health care program personnel or agents for the healthcare provider who have a need to know in the course of patient care activities or administrative operations. A copy of Bay County Health Department’s 500/501 certification by the Department of Health was provided. Interviews with seven youth were conducted to determine if they can request an HIV/Aids test to which all replied they could.

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.	

Sick Call Request forms are located in the cafeteria and in each dorm. Once a youth completes a Sick Call Request, then youth submits the Sick Call Request form into a locked box, which is located in the cafeteria and checked daily by the nursing staff. After lunch, direct care staff will notify medical with the number of sick calls for the day. A review of seven youth records found six had submitted Sick Call Request form. In all six Individual Healthcare Records (IHCR), the nurse completed the Sick Call Request form and filed it with the progress notes in reverse chronological order in each record. Four of the six youth records, a licensed practical nurse (LPN) conducted Sick Call. All four Sick Call forms were reviewed later the same day by a registered nurse (RN). When medical personnel are not on-site, the program has procedures in place where the shift supervisor will review the Sick Call Request forms as soon as possible and within four hours after the request is submitted. If medical personnel are not on-site, supervisors with the appropriate training can provide medication if necessary. Sick call is conducted daily after lunch Monday through Friday. A form is posted throughout the program accessible to the youth with the sick call days and times, Monday through Friday from 11:45 a.m. to 12:30 p.m. The Sick Call Request forms document notes in accordance with Health Services Rule 63M-2. All six IHCR were documented on the Sick Call Index and Referral Log. The RN was interviewed to determine who routinely conducts sick call and confirmed either the RN or LPN. The RN indicated sick calls are reviewed daily by the RN if sick calls are conducted by the LPN. The RN signs on the bottom of the Sick Call form if on-site. On days the RN is not on-site, the LPN notifies the RN by phone and reviews the sick call, then the RN signs the bottom of the sick call upon return to the program. The RN stated sick call is conducted in the medical area. The RN was interviewed regarding the process for referring youth to the designated health authority (DHA) when a youth has presented with repeated similar sick call complaints. She said the youth would be placed on the DHA site visit log and seen the next site visit day. One sick call was observed during this annual compliance review. The youth was escorted by direct care staff and met on the sidewalk outside the medical building by the RN, who escorted the youth to the medical area. The sick call was conducted in a private manner, away from all other youth, utilizing the exam table in the medical office. The RN identified herself and stated to the youth what she was being seen for. At the end of the exam, the youth was asked to sign the Sick Call Request form. During the exam, a RN, a licensed practical nurse (LPN), and the monitoring and quality improvement staff member was present, but no direct staff remained in the room with the youth during this sick call visit. Seven youth were asked how quickly they could see a nurse once a Sick Call Request was made. Four stated within a day, one said immediately, one stated within three days, and the last youth said she had never submitted a Sick Call Request. Seven staff were interviewed and asked who responds to sick call and all stated the nurse.

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 policy and procedures in place to ensure the provision of episodic care and/or first aid to youth in their custody. A review of seven records found four required on-site first aid or episodic care. In all four Individual Healthcare Records (IHCR), the date and time of the

episodic care, nature of the complaint, treatment provided, education/instruction given to the youth, placed on call-out to see the nurse, and the name and credentials of the medical staff who provided care was documented on the correct form. Three of the four applicable records received over-the counter medication, which was also documented on the correct form. In one of the four applicable records, the episodic care was after hours, therefore, shift supervisor consulted the registered nurse by phone. In the four applicable IHCRs, all had documentation reflecting medical personnel documented in problem-oriented (Subjective, Objective, Assessment, and Plan) elements. The program has dental and emergency medical care available, including emergency medical services (EMS) available twenty-four hours a day. There is a total of sixteen first aid kits in the program located in master control, each dormitory, kitchen, culinary, each case management office, breakroom, education employees' office, supervisor's office, and the laundry room. The first aid kits were fully stocked with contents approved by the designated health authority (DHA). According to the registered nurse (RN) and monthly inventory sheets, checks are conducted monthly on each first aid kit. The program stores the suicide response kits in each dormitory and in the supervisor's office. The program has one automated external defibrillator (AED), which is located in master control with the instruction guide. A licensed medical staff ensures the AED batteries and pads are operable. The AED batteries expire in June 2022 and were changed in 2018. The AED pads expire in November 2020 and were changed in August 2018. The program conducts announced and unannounced mock emergency medical drills, at least quarterly on each shift, which simulate an episodic care event requiring first aid and/or cardiopulmonary resuscitation (CPR) techniques, and the initiation of the emergency procedures to follow when a life-threatening emergency does occur. The program has a list of the emergency numbers, including Poison Information Control Center, posted in the medical personnel office and master control, where youth do not have access. The program has documentation of all medical personnel and supervisors have received appropriate training on the administration of the Epinephrine Auto Injector and shall administer the Epinephrine Auto Injector when needed. Seven youth were interviewed to determine if they can see a dentist if they have a tooth pain and all replied yes. In addition, youth were asked if they can see a doctor if needed. Six of the youth stated yes and one youth replied no. The program was made aware of the youth who replied they could not see the doctor. Seven staff were interviewed to determine if they are allowed to call 9-1-1 if a youth has a medical emergency and all stated they can. In addition, six staff confirmed they would notify the supervisor and one stated they would notify the program director.

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

The program has a policy and procedures in place to ensure timely referrals and coordination of medical services for all youth. A review of seven youth Individual Healthcare Records (IHCR) found four were eligible for off-site first aid or emergency care. Three of the four IHCRs had documentation of parental notification of the off-site visit. All four IHCRs had a Summary of Off-site Care form utilized, reviewed, and signed by the designated health authority (DHA). All four records had the discharge and other documents filed in each IHCR. Two of the four youth required follow-up testing, referrals, or appointments and each received the required follow-ups.

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

A review of seven Individual Healthcare Records (IHCR) found one was identified on the Facility Entry Physical Health Screening (FEPHS) form as possessing a current chronic condition, pregnancy. However, two more records were identified by the program as possessing a chronic condition which is not identified on the FEPHS form, body mass index (BMI). One of the three IHCR indicated the youth has a communicable disease, and two of the three were taking medications on an on-going basis. Two of the three youth were undergoing treatment for a physical health condition, increased BMI. All three youth had a medical classification between two and five. All three youth IHCRs indicated each was placed on the chronic illness list and had a specialized treatment plan. Two of the three youth received periodic evaluations at no greater than a three-month interval. The third youth will be receiving a three-month evaluation the week following the annual compliance review. The youth classified as pregnant received daily evaluations on-site with a licensed medical staff. This same youth has documentation of an on-site evaluation documented in the chronological progress notes, as well as treatment orders clearly written for clinical staff in her IHCR. Two of the three youth records had documentation of an off-site evaluation documented on the Summary of Off-site Care form and filed in each IHCR chronological progress notes. Each youth were seen by the designated health authority (DHA) for a follow-up and all off-site documents were reviewed and signed by the DHA. All three youth IHCRs had documentation of the periodic evaluations tracked on the correct form. The one youth record classified as pregnant has evaluation forms maintained in the active Pregnancy Book, while the other two youth records with increased BMI are in the active Chronic Clinic Book, then all forms are placed in each IHCR. According to documentation, there was no indication of lapses in care or missed periodic evaluations for all three records. The Department's Problem List was updated in accordance with the Health Services Rule 63-M, for all three records. The registered nurse (RN) was interviewed regarding how the program monitors youth with chronic conditions and indicated evaluations are conducted by the RN periodically, no less than once every three months. The DHA was interviewed regarding how often periodic evaluations are conducted for youth with chronic conditions and indicated as needed, but no longer than ninety days after the evaluation. The DHA reports medical staff review the program's chronic clinic book flow sheets to ensure all youth with chronic conditions receive a periodic evaluation.

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 to ensure youth medication is verified upon admission. A review of seven youth records found three were taking medication at admission. The medication was verified for all three youth prior to being accepted into the program. The medical personnel verify medication through prescription verification in the chronological progress notes in each Individual Healthcare Record (IHCR), Medication Administration Records (MAR), pharmacy, and/or parents/guardians. In all three IHCRs, the designated health authority (DHA) and/or psychiatrist were contacted to obtain an order to resume the specified medications youth is prescribed prior to admission. Three of the three records have a current, valid medication order and are given pursuant to a current prescription.

In all three IHCR, if the current medication was continued, discontinued, or changed, the DHA placed an order in the progress notes. Any over-the-counter (OTC) medication not listed on the Authority for Evaluation and Treatment, were administered in accordance with the program's approved protocols in all three youth IHCRs.

The standard Department MAR was used to document all medication and treatment, as well as clearly indicated when medication start and stop dates occurred for all three youth IHCRs. All three youth ICHRs indicated staff initials each time medication was administered and weekly documentation of side effect monitoring is documented on the MAR. Only nursing staff administered the medication for these three IHCR. The Six Rights of Medication Administration were maintained by both licensed and non-licensed staff. All refusals were clearly documented on the MAR and a Refusal form was completed and filed in all three youth ICHRs. All medications are stored in a separate, secure area inaccessible to youth, including non-controlled medications (prescribed and OTC). Narcotics and other controlled medications are stored behind two locks in the medication cart. Oral medications are not stored with injectable or topical medications and medications requiring refrigeration are stored in a secured refrigerator, which is used only for medication purposes. All syringes and sharps are stored in a secured cabinet. The medication cart was clean and organized with the stock items stored separately from youth specific medications. All expired or discontinued medication is stored in the bottom of the medication cart until the contracted pharmacist visits the program at the beginning of each month to take all medication off-site for disposal. One medication pass was observed during this annual review compliance. The Six Rights of Medication Administration were maintained. The registered nurse (RN) places the medication in a cup, then the youth is given a cup of water to swallow the medication. The medication is taken by the youth with another drink of water, the youth's mouth is swabbed by the RN, and the RN requests the youth to cough. Seven youth were interviewed to determine who gives them their medication and what is the process. All seven replied the nurse and one added staff. The youth described the process as follows: medications are given during medication pass, during certain times depending on the medication, sometimes in the evening by a shift leader if the youth has a headache, and medications are given depending on the when the youth meets with the dentist or doctor. Seven staff were interviewed and asked who provides medication to youth. All seven staff stated the nurse, two added the supervisor, and one added a supervisor who is trained to give OTC 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.	

All medication equipment classified as sharps are secured and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed. All medications are identified and secured in the locked area designated for storage medications, with different medication forms being separated. All controlled substances had a perpetual inventory, were stored separately behind two locks, and had two separate keys in the medication cart. All expired or discontinued medication is stored in the bottom of the medication cart until the contracted pharmacist visits the program at the beginning of each month and to take all the medication off-site for disposal. A perpetual and weekly inventory of all sharps and stock over-the-counter medications were conducted. Pursuant to Board of Pharmacy regulatory requirements, a shift-to-shift inventory count of all controlled substances was documented on the youth's Individualized Controlled Medication Inventory Record. Inventory was completed on

two youth medications, one included a controlled medication, and three over-the-counter medications, and three sharps indicating no inventory discrepancies. Documentation was provided of the supervisory level staff, non-health care, who are trained in delivery and oversight of medication self-administration who can perform these duties. The number of pills, tablets, or dosages remaining after each administered dosage was documented on the youth's Individualized Controlled Medication Inventory Record received with the medicine from, the pharmacy, or the Department form. According to the registered nurse, if there is an inventory discrepancy, a re-count would take place immediately, notification to the program director, an internal investigation, incident report, and corrective action would occur.

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's infection and control expose plan included all the following; common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B, and C and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens, other outbreaks or epidemics caused by any other infectious agent, whether spread directly or indirectly, outbreaks of pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms, food-borne illnesses, bio-terrorist agents, chemical exposures in the workplace, Hepatitis B immunization available to staff, staff having access to protective equipment, and documentation where Standard Universal Precautions are followed by all staff. The program has not had any instances in which the local county health department, Centers of Disease Control and Prevention (CDC), and/or the Department's Central Communications Center (CCC) should have been notified of an infectious disease since the last annual compliance review. The program has a comprehensive process for needle stick post-exposure evaluation and maintains a separate file containing all documents for youth and staff who have experienced a facility/occupational exposure and are maintained for a period of ten years. The program's Exposure Control Plan was written in accordance with Occupational Safety and Health Administration (OSHA) standards and is available to all staff. This plan is located with the Continuity of Operations Plan (COOP) in master control and the medical building. The plan was reviewed and signed annually by the program director on September 19, 2019. The plan included Risk Assessment and Methods of Compliance. The program did not have three or more cases of any reportable infectious disease needed to be reported to the local health department and/or CDC. On April 12, 2019, the program had a total of thirty youth on the census and five of the youth were identified with influenza symptoms, which was ten percent of the program's population. The CCC was notified within two hours. All five youth were tested for influenza on-site with two youth testing positive. This did not meet the threshold of ten percent of the population. The program quarantined all five youth as a precaution and the CCC incident was closed on April 16, 2019 with informational purposes only. An interview with the program director confirms the Exposure Control Plan is kept in master control and in the medical office. The program director also confirms the Exposure Control Plan is reviewed annually with all staff.

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

The program has a written policy and procedures to ensure nutritious foods, in sufficient quantities, which met the standards of the minimum daily allowance for pregnant youth. All non-healthcare staff involved with the supervision or treatment of these youth received the appropriate education. A review of seven youth records found one was applicable, therefore, an additional two records were pulled for review of prenatal care for all pregnant youth. All three Individual Healthcare Records (IHCR) had documentation of prenatal care beginning immediately upon determination the youth was pregnant, continued until discharge, and through post-partum. A licensed nurse provides in-service education on girls' healthcare annually to all non-healthcare staff, including training on monitoring and observation of emergency needs of the pregnant youth. All reviewed applicable youth records indicate each were placed on the internal alert list for vital nutrition and health awareness for staff. All youth received education on the following topics: alcohol and drug usage, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. All records had documentation of a plan of care through post-birth to include psychological and physical care. Prenatal care was offered at recommended intervals as well as a human immunodeficiency virus (HIV) test, after counseling by the designated health authority (DHA) for all three IHCR. If the youth declined the HIV test, a refusal waiver was documented in the IHCR. The DHA conducted a medical evaluation at least every thirty days on two of the three IHCRs. The third youth arrived at the program on September 23, 2019 which was not due for a medical evaluation at this time. In two of the three youth records, the youth complained of issues related to pregnancy and the DHA was notified immediately. All three IHCR had documentation of daily monitoring for danger signs of pregnancy complications by a licensed staff. One of the three records was applicable for receiving prenatal and/or postnatal care at recommended intervals. The other two youth are currently pregnant. All three youth records included documentation a licensed medical staff provided routine monitoring of the pregnant youth's nutritional and weight status daily during their pregnancy. Documentation was provided verifying all non-healthcare staff received in-service training annually in supervision or treatment of pregnant youth by a licensed nurse. This in-service training included observation and monitoring of emergency care needs/symptoms of possible miscarriage. Seven youth were interviewed regarding if they have received prenatal, obstetrical, or gynecological services at the program, which one youth stated yes, the other six stated no as they were not pregnant.

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-eight during awake and sleep hours, and one-to-five for off-site activities or when youth are working with tools. The policy and procedures outlined supervision practices which contain the following: reinforcement of expectations, proper positioning, informal counts, and staff awareness. On the first day of the annual compliance review, youth were observed in education classes and movement between areas in which youth were searched entering and exiting each room. On the second day, youth were observed in the classroom, during breaks, and entering or exiting the cafeteria. On the third day, the youth were observed in the mental health groups, treatment team meetings, breaks, recreation, and entering the cafeteria. On the fourth day, youth were observed during breaks, classroom and being escorted to different activities in the program. The reviewer observed these activities both in person and on camera. Staff were randomly asked how many youth were under their supervision throughout the annual compliance review week, and each could immediately report the correct number of youth. At no time throughout the annual compliance review were youth observed to be unaccounted for or unsupervised. Prior to every youth movement, youth were observed being searched by staff. Positive interactions, disciplinary issues were observed between staff and youth. Also, the consistent application of the behavior management system were observed throughout the annual compliance review. The program's activity schedule contains a full schedule of daily activities. The activity schedule was observed posted in each dorm and throughout the rest of the program. The shift supervisor, who also serves as the master control operator, was interviewed regarding count discrepancies. The shift supervisor explained, if counts cannot be reconciled, movement will stop, all youth will be brought to the pavilion area, and a recount will commence until the count can be reconciled.

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

The program has a written policy and procedures outlining behavior management strategies designed for youth to comply with daily rules and expectations, as well as offer guidance to change behaviors, thus increasing accountability for the youth. The program's behavior management system (BMS) is clearly written and has not changed since the last annual compliance review. The BMS system includes a wide variety of rewards, appropriate consequences, immediate application of consequences in which staff must explain and

communicate, and a four-to-one ratio of positive-to-negative consequences. The BMS was not observed posted throughout the program; however, is clearly written in the youth handbook. All seven reviewed youth records reflected documentation of receipt of handbook and orientation which was signed and dated by staff and youth. The BMS system consists of five levels: Orientation, Direction, Opportunity, Values, and Excel/Transition. In addition to a level system, a point card system is utilized. Points are awarded to each youth based on personal responsibility and participation in activities throughout the day. Youth can then exchange points at the point store weekly and purchase various items such as candy, snacks, drinks, hygiene items, minutes for phones calls, and yarn for craft projects. Youth who display positive behavior are able to participate in movie nights and request to participate in a variety of off-campus activities. Seven interviewed youth were able to explain the program's level system, as well as, describe types of rewards and consequences. Seven interviewed youth were to describe the BMS to include incentives offered to the youth. One of seven interviewed staff reported incentive items such as personal tennis shoes can be taken away from youth consequently, in which case, the youth would have to wear the program issued shoes. The remaining six interviewed reported things could not be taken away from youth as a consequence. According to the program director, the BMS can be found in the youth handbook, point cards are entered weekly to track the youth's progress, and this information is discussed in the youth's treatment team meeting.

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

The program has a written policy and procedures ensuring staff are provided with feedback regarding their implementation of the behavior management system (BMS). The program does not use room restrictions; therefore, this was not observed by the annual compliance review team. 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 maintains an excel spreadsheet in which point totals are entered in for each youth. This information is available for review at each youth's treatment team meeting. The point cards contain areas for both positive and negative feedback from staff, as well as a list of triggers specific to each youth to help staff respond to each youth appropriately. According to the written policy and procedure, staff receive feedback based on their utilization of the BMS at any time. A review of a sample position description for a team leader and shift leader reflected implementation of the BMS as an essential function. A review of the provider's contract reflected all required parties were involved in the development, implementation, and on-going maintenance of the BMS. Documentation in seven pre-service and seven in-service staff records reflected all completed training on the BMS. Further, staff members, including education staff, are trained in the use of the BMS during school. Each of the seven interviewed staff reported youth are informed of consequences immediately and are given an opportunity to explain themselves. Six of seven interviewed youth reported youth are

not allowed to punish other youth, one youth reported they are but when asked if something has happened by the interviewer, the youth responded “maybe…maybe not.” Five of seven youth reported staff are consistent with the application of rewards; one reported staff are not consistent and one reported staff are sometimes consistent. According to the program director, the BMS can be found in the youth handbook, point cards are entered weekly to track the youth’s progress, and this information is discussed in the youth’s treatment team meeting.

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 written policy and procedures addressing youth supervision which states when youth are in their sleeping areas, staff will observe each youth in their room at least once every ten minutes. In addition, the policy states a random thirty-minute check by the shift supervisor shall also be documented. The program has sixty-two cameras in which all are operational. Video surveillance footage is stored for thirty days. The program currently has four shifts: day one, day two, night one, and night two. The program has five dorms: Anne Frank, Eleanor Roosevelt, Lucy Stone, Mya Angelo, and Rosa Parks. A review of video surveillance was reviewed for each shift and each dorm on four separate dates. Staff were observed going to each room and looking in at each youth on the video footage. Documented ten-minute check times were consistent with the ten-minute checks observed on the video footage. Documentation for the ten-minutes checks reflected the actual time of the check and included the staff’s initials conducting the checks, as well as the random supervisor’s checks. Seven of seven interviewed staff reported room 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.*	

The program has a written policy and procedures outlining counts and daily census. According to the procedures, the shift supervisor is responsible for all counts which include: formal, informal, and emergency counts. Camera footage reflected the program conducts counts at the beginning and end of each shift, as well as for all movement. Counts were observed taking

place throughout the annual compliance review. Counts were observed to be documented in the master control logbook. Logbook documentation also reflected daily census counts, head counts, youth movements, new admissions, releases, transfers, and youth off-site. Additionally, counts are conducted at the beginning of each shift, after each outdoor activity, and during mock drills. All seven interviewed staff reported counts are conducted at the beginning and end of each shift, as well as throughout the day during any movement. Additionally, seven of seven staff reported if there is a discrepancy in count, all movement stops, and a recount is conducted.

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

The program has a written policy and procedures addressing logbooks and shifts reports. Logbooks were observed to be bound with numbered pages, not falling apart or missing any pages. Logbooks for the previous six months were reviewed. The program documents the following: emergency situations, incidents, special instructions for supervision and monitoring of youth, population counts, security checks, transports away from the program, requests by law enforcement to access any youth, removal of youth from general population, information related to escape or attempted escape, youth placed on observation, admissions, and releases. Logbook entries were made with black/blue ink. Any errors were struck through with a single line, dated, and initialed by the person correcting the error. No errors were observed. Each entry observed included the date and time of event, the name of the staff and youth involved, a brief description of the event, and the name and signature of the staff member making the entry. The program documents specific entries with colors such as orange for mental health, yellow for safety and security related entries, blue for medical, and pink for calls the Department's Central Communications Center. The program does not maintain living unit logbooks. Shift reports are completed by each shift supervisor and include a summary of events, incidents, activities, and alerts. Each incoming staff member must review and sign indicating they have reviewed the shift report before exiting the master control. Additionally, the shift supervisor will verbally brief staff about the contents of the reports.

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

The program has a written policy and procedures addressing key control. The program's key control system includes: key assignment and usage including restricted keys, inventory and tracking of keys, secure storage of keys when not in use, procedures addressing missing or lost keys, and reporting and replacement of damaged keys. Observations of distribution and the collection of keys was observed during the annual compliance review. A review was completed of the daily inventory in which five keys were examined by the reviewer. The inventory is

completed at the beginning and end of each shift. The inventory is submitted daily to the safety officer who also reviews and signs the inventory. A review of the key inventory was conducted, one key was mistakenly marked as having four keys on it, when it only had three. This discrepancy was noted by the reviewer and reported to the safety officer (assistant program director). The safety officer reported the key (to an exterior gate in which youth do not have access to) was no longer in use and recently removed, however the chit on the key ring was not updated to reflect the change. The issue was corrected by the safety officer within minutes. Keys are stored in a locked cabinet when not in use and only the shift supervisor has access to the key cabinet during the shift. Youth do not have access to this area. The key assignments are made based on a staff's position. Certain areas have limited or restricted access (medical, food storage, youth records, staff records, administration) and are, therefore, only assigned to staff which require access to these areas. A visitor's personal keys are turned in and stored in a secure lock box in master control. The visitors receive a chit with an assigned number and once they leave the facility the visitor keys will be returned to them once they present the chit back to the master control staff. In the event a key is lost, the program's procedure states it shall be reported immediately to the shift supervisor, the program director will be notified, a search will be conducted, and an incident report will be completed. If a key is damaged and needs replacing, staff will notify their supervisor and a maintenance request form will be completed. The program reported it has not had an incident of lost or missing keys in the past six months. A review of internal incident reports and the Department's Central Communications Center (CCC) reports verified this information. According to the master control operator, permanent or restricted keys are signed for and no other staff can utilize these keys. A random check of three staff members revealed the key they had on them were the keys they signed for upon reporting to work, none had their personal keys on them. Seven interviewed staff were able to explain the key control process and what to do in the event of a lost or damaged key.

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

The program has a written policy and procedures which addresses the prevention and searches of contraband within the facility grounds. The program's policy also incorporates the Department of Juvenile Justice Guidelines Relating to Contraband in Residential Facilities from August 2015. The program defines items and materials considered contraband. Youth are provided with a list of contraband within their youth handbook, which is issued and discussed upon their

admission to the program. Youth are informed of search procedures. The program's policy includes searches of the physical plant, program grounds, and searches of incoming and outgoing mail. Program administrative staff were interviewed and confirmed all youth correspondence is searched in the youth's presence. The results of the searches are documented and placed in the youth's case record. A sample of youth records were reviewed to confirm this practice. An interview with the assistant program director revealed there has been no illegal contraband discovered during the scope of the annual compliance review. The policy indicated any illegal contraband which should be discovered will be turned over the law enforcement. The program's policy, employee handbook, and staff's list of contraband items address violations of work standards and disciplinary action to include unbecoming conduct and willful violation of laws and program rules. The assistant program director performs weekly safety and security audit inspections and reports the findings to the Department's Residential Operations staff. The inspections consist of a walk-thru of all program areas to ensure areas are clean, free from security issues, and cameras and equipment are working properly. In addition, the program performs searches of randomly selected program areas for each shift daily. The completed search forms are maintained in binders. A review of these for the previous six-months found the program completed them consistently. The search forms documented the areas searched, who is performing the search, the date the search was conducted, what items were discovered, and the disposition of any contraband found. The program director was interviewed and stated if contraband is discovered, a contraband report is submitted to the safety and security officer, who will then retrieve the contraband, dispose of it, and document it as 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 has a written policy and procedures addressing youth searches. During the annual compliance review, youth were observed being searched entering and exiting the dorms, cafeteria, education and vocational classes, prior to transport, and before and after treatment team meetings. Each youth was observed being searched by a staff member of the same sex and was treated with dignity and respect. Neither an admission or visitation was able to be observed during the annual compliance review. According to procedures, all new admissions and youth returning from a home visit participate in a full body visual search by two staff members of the same sex. The purpose of the search is explained to the youth and searches are conducted in accordance to the Protective Action Response (PAR) training manual. All seven interviewed youth reported searches are conducted when returning after visitation. Six of the seven interviewed reporting searches were also conducted after returning from any off campus activity and after meals. Seven staff reported youth are searched during all movement, leaving and returning to campus, going inside and outside, and after vocational activities. Searches are also outlined in the student handbook.

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

The program has a written policy and procedures ensuring all vehicles which transport youth are appropriately maintained and operational. The program utilizes three vehicles to transport youth. A separate maintenance binder is kept for each vehicle. Documentation reflected each vehicle had an annual safety inspection completed, as required. All three vans were equipped with the appropriate number of seatbelts, a seatbelt cutter, window punch, and fire extinguisher. First aid kits are not stored in the vehicle and must be signed out for transport in master control. First aid kits designated for transport were observed and contained all approved items. A random check of personal vehicles in the parking lot was completed during the annual compliance review, in which the vehicles checked were found to be secure. A transport was observed during the annual compliance review. Staff and youth were both observed wearing seatbelts. At no time during the observation was the youth attached to any part of the vehicle by any means other than a seatbelt.

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

The program has a written policy and procedures addressing youth transports and ensures compliance of all requirements outlined by the Department relating to the transportation of youth and driver eligibility. According to the program's written policy and procedures, staff to youth ratio for youth transport is one-to-five and requires two staff members for youth who pose a high security risk. Three youth transports were observed at various times during the annual compliance review. Each youth was searched by a staff member of the same gender. The transporting staff member was observed checking out a first aid kit in master control, as well as a cell phone for transport. All youth and staff were observed securing their seatbelts prior to leaving the program. Vehicles utilized for transport do not have youth passenger doors which can be opened from the inside. Youth do not operate vehicles and are not left unsupervised in the vehicles. The program maintains a list of approved drivers in which a driver's license check is conducted annually by the program's business manager/human resource specialist through Florida Department of Highway Safety and Motor Vehicles (FDHSMV) for each of those staff members. Each of the seven interviewed staff reported they do not use their personal vehicles for transporting youth. Additionally, all staff reported a transport phone is checked out in the shift supervisor's office prior to a transport.

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 outlining the weekly safety and security auditing process to include who is responsible for conducting the audits, the development of any

corrective actions needed, and an internal system to verify the deficiencies are corrected, and existing systems improved to maintain compliance. A review of the policy revealed it met the requirements of Florida Administrative Rule. The assistant program director is the staff designated to complete these checks as required. The program maintains copies of all completed Weekly Safety and Security Audit check sheets. A review of these documents found the program completes the process every seven days as required. The documents are forwarded through email to the Department's safety and security specialist for Residential Operations. Telephone contact was also completed with the safety and security specialist who confirmed the program consistently provides the weekly inspection sheets as required.

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

The program has a written policy and procedures addressing tool inventory and management. Maintenance staff does not keep tools on-site, but rather brings tools to the program, as needed, for repairs. A maintenance tool binder was available for review in which maintenance staff signs tools in and out, as needed. The program's administrative assistant or shift supervisor verifies the tools maintenance brings in and out of the program. Tools which are utilized in the kitchen and in culinary class and kept in a secure storage box with a shadow board. These items are inventoried daily and monthly, as well as signed in and out as they are used. Inventory and sign in/out sheets were available for review. Each week these sheets are submitted to the safety officer for review. Each dorm has two brooms, one mop, one mop bucket, and one dust pan assigned. Inventories for these items were also available for review and matched the items in each of these areas. All tools are stored when not in use, in an area not accessible to youth. Tools are clearly marked for easy identification. Tools are inventoried prior to being issued for work and following work activities. Machetes, bowie knives, and other long blade knives are prohibited. Dysfunctional tools are disposed of and replaced, as needed. The following staff members have been trained in the proper procedures for handling tools: program director, safety and security officer, human resources, case managers, shift supervisors, team leaders, and kitchen staff. A sample of personnel records were reviewed for a staff member holding each of these positions. Documentation reflected staff were trained on the intended and safe use of tools. Based on the interviews of the seven youth, they are only allowed to use the mops and brooms. One youth reported they are allowed to use scrub brushes and three youth reported they use knives in culinary class. In the event a tool is lost or missing, a Tool Report form is completed, and the safety officer is notified immediately. A search of the program and the youth will be conducted until the item is located. If the item cannot be located, and is determined linked to another reportable incident, the Department's Central Communications Center (CCC) will be notified within the required timeframe. Seven interviewed staff reported youth use mops, brooms, and kitchen knives in culinary class.

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

The program has a written policy and procedures addressing youth handling tools. According to the written policy and procedures, when using tools, the staff to youth ratio is one-to-five during work activities or vocational training. At the time of the annual compliance review, no youth were observed in culinary class using knives. The culinary instructor acknowledges how to access

knives out of a secured lock box located in a locked closet, signing out the knives and issuing the knives to youth if required. The culinary instructor reported she limits access to all culinary knives to the youth. The instructor additionally reported once the knives were no longer needed, the youth washed the knives off in the sink and returned them to the instructor, who signed the knives back in on the log and returned to the secure lock box in the closet. Risk assessments are completed for all youth in the program. The risk assessment indicates if youth are authorized to work with tools. Youth were observed throughout the annual compliance review week being searched upon entering and exiting education and vocational classes. Seven interviewed staff reported youth use mops, brooms and kitchen knives in culinary class.

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

The program has a written policy and procedures outlining the process for outside contractors. A binder for outside contractors was available for review. All outside contractors are required to sign a vendor agreement prior to entering program which includes: all tools are inventoried prior to entering and exiting the program, what tools are restricted by the program, youth restriction from the work area, and missing tool procedures. The vendor agreement is signed and dated by the contractor and witnessed by a staff member. Additionally, the contractor then completes a tool inventory sign in and out form which is also verified/witness by the administrative assistant or shift supervisor. The binder for outside contractors was available for review. According to the written policy and procedures, the program director may authorize the introduction of an electronic device into the secure area by a visitor if the device is issued by the visitor's employer for the purpose of conducting official business.

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

The program has a written policy and procedures ensuring fire, safety, and evacuation drills are conducted to ensure the youth and staff are prepared for immediate implementation in the event of an emergency or disaster. The program conducts fire and safety drills monthly and on each shift. Drill documentation was available for review. Drill documentation included: the type of drill, date and time, participants, a brief scenario, and findings/recommendations. Drills for the previous six months included monthly fire drills, six safety-related drills, seven evacuation drills, and four disaster-related drills. Fire evacuation route and egress plans were observed posted throughout the program. According to the program director, all shifts are required to conduct drills, these drills include, but are not limited to, fire, severe weather, program disturbances, workplace violence, bomb threats, poisoning, and suicide drills. Seven interviewed youth report they participate in fire drills and could explain what to do during the drill. Seven interviewed staff report they have participated in the following drills: weather, major disturbance, suicide, medical, fire, and escapes.

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

The Continuity of Operations Plan (COOP) is conspicuously posted throughout the program and is readily available to staff and youth. The COOP is located in the program director's office, shift supervisor's office, medical office, and training building. The COOP is reviewed and updated annually. The COOP was last reviewed on March 1, 2019 and submitted for Department approval on April 1, 2019, which the Department approved on the same day. The plan addresses alternative housing plans approved by the Department's regional director. The program's disaster plan and COOP are one combined plan. The program's COOP included: fire prevention and evacuation, severe weather, program disturbances, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, equipment and supplies, information about the youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody, and provisions for public protection. Provisions of equipment and supplies required for continuous operation and services during an emergency or disaster situation were observed. According to the program director, the COOP is located in her office, the shift supervisor's office, the training building, and medical building.

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 flammable, poisonous, and toxic control. According to the procedure, a current list of staff authorized to handle chemicals is maintained at each location in which chemicals are stored. The list of authorized staff was observed to be posted in locations in which chemicals are stored includes the program director, safety and security officer, human resources, case managers, shift supervisors, team leaders, and kitchen staff. Flammable, poisonous, and toxic items are secured at all times in areas inaccessible to youth. Chemicals used in the kitchen were observed to be stored in a locked closet. Chemicals used on the dorm are stored in a closet behind two locked doors. Inventories are maintained for flammable, poisonous, and toxic items. Inventories matched the items on hand and included corresponding Safety Data Sheets (SDS).

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

The program has a written policy and procedures addressing youth handling and supervision for flammable, poisonous, and toxic items and materials. The program maintains strict control of all flammable, poisonous, and toxic items and materials. Youth do not use, handle, or clean up dangerous or hazardous materials. Youth do not clean, handle, or dispose of any person's bio-hazardous material, bodily fluids, or human waste. Flammable, poisonous, and toxic items are always secured in areas inaccessible to youth. Youth were observed during the annual compliance review cleaning the cafeteria. Two youth were observed on video surveillance sweeping and mopping the floors, as well as, wiping down the table in the cafeteria. At no time were youth observed spraying or handling cleaning agents or other chemicals. Staff maintained supervision of the youth cleaning at all times. The program's preventative maintenance checklists were observed to be conducted as outlined in F.A.C. 63E-7.109. Four of the seven interviewed youth report they do no use chemicals or cleaning agents. Two of the seven youth interviewed report using paint and one of the seven stated they used gasoline. The one youth who reported using gasoline is a youth who works with the Department of Transportation. The program does maintain gasoline on facility grounds.

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

The program has a written policy and procedures which outlines the process for disposal of flammable, toxic, caustic, and poisonous items. Disposal procedures are completed in accordance with Occupational Safety and Health Administration (OSHA) Standards. A review of the program's chemical storage found a limited supply of cleaning products. The program reported they do not maintain gasoline on the program grounds. An interview with the dietary staff found dirty mop water is disposed of through floor drains and mop sinks. Any grease or oil is disposed of by pouring it back into its original plastic container, sealing it, and dumping in the trash bins. An interview with the program's registered nurse (RN) was completed. The RN stated all bio-hazardous medical waste is disposed of into marked containers. The containers are then boxed, sealed, and mailed to contracted waste management facility. The program maintained a disposal log of the waste once it is packaged and sent out to be disposed of on an as-needed basis. The positions authorized to dispose of these items are the RN and the

licensed practical nurse (LPN). Staff responsible for the disposal of all hazardous waste have received training for hazardous items and toxic materials. According to the program director, all hazardous materials are disposed of in accordance with state and local regulations.

5.21 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Satisfactory Compliance

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 has a written policy and procedures in place related to water activities. The program does not currently have a staff member who is a certified lifeguard. The program has not conducted any water activities since the last annual compliance review. According to the program's written policy and procedure, the water safety plan in place addresses safety issues, emergency procedures, and rules to be followed during water-related activities. Swim tests will be conducted prior to youth participation in water activities. Risk assessments contain: whether the youth can swim, assessment of swimming abilities, factors such as age or maturity, special needs such as physical or mental health issues, physical stature, and conditioning. An example of a risk assessment was available for review. Site surveys will be conducted for every location in which an activity is planned. The site survey includes water conditions such as clarity, turbulence, and bottom conditions, as well as the type of activity being conducted. An example of a water activity site survey was available for review. Proper safety equipment is used for all activities. The program's written policy and procedure reflects the lifeguard to youth ratio during water activities is one-to-twenty. The program provides additional staff to ensure a supervision ratio of one-to-five is maintained during a water activity. The policy also states the lifeguard shall

not be counted in the one-to-five staff supervision ratio. Staff are trained in emergency procedures. Seven of the seven interviewed youth report they have not participated in a water activity.

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

The program has a written policy and procedures which outlined the visitation schedule for youth. Visitation is conducted on Sundays from 1:00 p.m. until 4:00 p.m. The visitation schedule was observed posted within various program areas. Procedures for visitation, as well as telephone and mail procedures were also noted within the youth handbook. A review of three youth case management records revealed each youth received and signed for a youth handbook upon their admission. The program allows youth the opportunity to participate in home visits, when they are on the appropriate level in accordance with the behavior management system, and if they are within the transition phase of their commitment. An interview with program administration also revealed alternative visitation arrangements are given with parent/guardians if the situation is needed. In addition to visitation, youth are afforded the opportunity to communicate with family through mail and telephone. Youth are given two letters a week to mail home. Youth are also given the opportunity to make a call home once a week. According to the written policy and procedures, all incoming and outgoing mail is checked by the assigned case manager for contraband. This was also confirmed through an interview conducted with the clinical director and program administration. A review of seven youth records was done and found evidence the search of mail was documented on the Package Inventory Form. Seven youth interviews were conducted and all confirmed they are given the opportunity to speak with family on a regular basis.

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 utilize controlled observation; 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 utilize controlled observation; therefore, this indicator rates as non-applicable.

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

The program does not utilize controlled observation; 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 addressing youth safety plans. The instrument was developed by the program and contains warning signs identified by the youth. The youth's baseline of behaviors is gathered in conjunction with the youth and evaluations. The instrument also covers crisis recognition with identifying both verbal and non-verbal stimuli. Jointly developed coping strategies were included along with invention strategies preferred by the youth. A review of seven youth records found all had a safety plan developed within fourteen days of admission. However, the safety plans were only developed with the therapist and youth. According to the therapist, there was no collateral development with parents/guardians or other family members. All safety plans incorporated all recommendations from previous and current clinical assessments. The instrument incorporated trauma responsive practices. A review of seven safety plans found none had been updated every thirty days or following any significant behavioral or mental health event. The youth safety plan binder is located in the shift supervisor's office. Five of seven interviewed staff reported youth safety plans are located in the shift supervisor's office; one reported in case management and one was unsure of their location. Three of seven staff reported they review safety plans regularly, one reported she reviews their point cards for triggers, and two staff reported they do not review safety plans. Two of seven youth reported they were part of the development of their safety plan, three were not familiar with what a safety plan was, one reported no, and one reported she did not think so but knew what a safety plan was.