STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Duval Academy
Sequel TSI of Florida, LLC
(Contract Provider)
7500 Ricker Road
Jacksonville, Florida 32244

Review Date(s): April 23-26, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Mike Marino, Office of Program Accountability, Lead Reviewer (Standard 4)
Alisa Bishop, DJJ Probation, Circuit 4, Juvenile Probation Officer Supervisor (Standard 2)
Katina Horner, Office of Program Accountability, Regional Monitor (Youth and Staff Interviews)
Jillian Lewandowski, Office of Program Accountability, Regional Monitor (Standard 3)
Aaron Mathews, DJJ Bureau of Contracts, Senior Management Analyst Supervisor (Standard 5)
Gwen Nelson, Office of Program Accountability, Regional Monitor (Standard 1)

Program Name: Duval Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Duval County / Circuit 4
Review Date(s): April 23-26, 2019

MQI Program Code: 1280
Contract Number: 10094
Number of Beds: 28
Lead Reviewer Code: 37

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☐ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- **1** # Case Managers
- **1** # Clinical Staff
- _____ # Food Service Personnel
- **2** # Healthcare Staff
- **1** # Maintenance Personnel
- **1** # Program Supervisors
- **5** # Staff
- **5** # Youth
- **1** # Other (listed by title): **Education Coordinator**

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	* Initial Background Screening	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	* Provision of an Abuse-Free Environment	Satisfactory
1.04	* Management Response to Allegations	Satisfactory
1.05	* Incident Reporting (CCC)	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	* Pre-Service/Certification Requirements	Satisfactory
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	*Internal Alerts System and Alerts (JJIS)	Limited
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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	* Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	* Treatment and Discharge Planning	Satisfactory
3.08	* Specialized Treatment Services	Satisfactory
3.09	* Psychiatric Services	Satisfactory
3.10	* Suicide Prevention Plan	Satisfactory
3.11	* Suicide Prevention Services	Satisfactory
3.12	* Suicide Precaution Observation Logs	Failed
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	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Room Restriction/Controlled Observation	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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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	Limited
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	Limited
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 Handlins and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Recreation and Leisure Activities	Satisfactory
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Non-Applicable
5.25	Controlled Observation	Non-Applicable
5.26	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

Duval Academy is a twenty-eight-bed program, for fourteen to eighteen year old males, located in Jacksonville, Florida. The program is operated by Sequel TSI of Florida, LLC, through a contract with the Department. The program provides substance abuse treatment overlay services (SAOS). In addition, the program fosters each youth by providing Thinking for a Change (T4C), Impact of Crime, Living in Balance, Aggression Replacement Training (ART), Talks My Father Never Had with Me, and Seeking Safety. Additional treatment services provided include individual, family, and group therapy.

Program administration is comprised of a facility administrator, assistant facility administrator, clinical director, and business manager. The clinical manager was out on maternity leave at the time of the annual compliance review and Sequel's regional clinical director was serving as the program's clinical director. Case management services are provided by two case managers and a transition specialist, who report to the clinical director. Mental health staff at the program includes the clinical director, two master's-level therapists, and a recreational therapist. Medical services are offered daily from 7:00 a.m. to 7:00 p.m. and are provided by a contracted medical doctor (MD), who serves as the designated health authority, a contracted psychiatrist, and two full-time registered nurses. Educational services are provided by the Duval County Public Schools. The layout of the program includes main building, which includes administration, staff offices, youth living areas, dining room, kitchen, a classroom, and large meeting area or pavilion. There are also two trailers used as classrooms. The program has fifty-seven cameras operating security cameras providing coverage. At the time of the annual compliance review, the program had one youth care worker position vacant.

Strengths and Innovative Approaches

- Youth are supported and mentored by the National Naval Officers Association (NNOA) on a monthly basis. Annually, the NNOA awards three scholarships in the amount of $500 each to program youth and alumni. In addition, the Duval New Beginning Scholarship is awarded to youth accepted to college on any level.

- The program has had fifteen youth graduate from high school. The program had a ceremony with two guest speakers to congratulate the youth on their achievement and encourage other youth to purse their education.

Standard 1: Management Accountability

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

The program has a policy and procedures for conducting initial background screenings of new employees, volunteers, interns, and contracted staff. Since the last annual compliance review, the program reported no new volunteers or interns. The program hired twenty-two new full-time employees and one contracted medical doctor. All new employees and the contracted medical doctor received an initial background screening prior to their hire date. Criminal history reports, pre-employment assessment, the Central Communications Center person involvement reports, SVS, and FDLE reports were also found in each of the staff records. An Annual Affidavit of Compliance with Level 2 Screening completed and submitted to the Department's Background Screening Unit (BSU)for program staff and education staff on December 27, 2018.

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

The program has a policy and procedures to complete five-year background rescreenings. The program's staff roster found none of the staff required a five-year background rescreening.

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

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

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

The program has a policy and procedures in place to ensure an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse and harassment. The program has a code of conduct which all staff are required to sign. Each of the reviewed staff records contained a signed code of conduct, as well as documentation the staff received training on the code of conduct. The program's policy prohibits staff from denying a youth a call to the Florida Abuse Hotline and the Central Communications Center (CCC). The Florida Abuse Hotline telephone number and the Central Communications Center telephone numbers were posted throughout the facility. Five youth were interviewed. All youth said they felt safe in the program. The five youth were asked if they had ever been denied a call to the Florida Abuse Hotline or the CCC and all youth answered no. The five youth reported staff are respectful when speaking with them or other youth and they have not heard staff use profanity. A youth can request a call to the Florida Abuse Hotline or CCC by asking the staff and the staff will inform the shift supervisor of the youth's request. The youth is taken to front office, where the staff dials the number and the youth is given the telephone. Interviews with five staff revealed they have never observed a co-worker using profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth. The facility administrator (FA) interview indicated knowledge of the requirements for a youth requesting a call to the abuse hotline or the CCC. The FA also acknowledge the program's policy to prohibits staff from verbally, mentally, or physically abusing youth.

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 policy and procedures to respond to allegations regarding any incidents of physical, psychological, or emotional abuse. A review of all incidents reported to the Central Communications Center (CCC) and Florida Abuse Hotline since the last annual compliance

review indicated the program had four substantiated incidents related to physical abuse. Management took immediate actions to address the four incidents by providing additional training for staff and terminating one staff. Based on the facility administrator (FA) interview, the FA has a clear understanding of the policy and procedures for to respond all allegations of abuse.

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

The program has a policy and procedures in place regarding incident reporting. The program had nineteen Central Communications Center (CCC) reports in the last six months. Five of the nineteen reports were randomly selected for review. All five incidents were reported within two hours of the program gaining knowledge of the incident. Four of the five calls were documented in the facility logbook. One call was not applicable to document in the logbook, as it involved an incident with staff outside of the facility. A review of internal incidents and grievances found there were no additional incidents which should have been reported to the CCC.

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 policy and procedures to document Protective Action Response (PAR) incidents. The program had one PAR report since the last annual compliance review. The report was dated October 8, 2018. The report was completed by the end of the staff member's workday. The report included statements from all staff involved. One staff member involved in the PAR was placed on administrative leave and later terminated. The report was reviewed by a supervisor and a PAR instructor. A PAR medical review was conducted for the youth. The program's PAR plan was approved by the Department's Office of Staff Development and Training on November 30, 2018. The facility administrator confirmed the training coordinator or designee maintains all computerized or written training records demonstrating in-service training requirements, along with PAR incidents. The program experienced a minor increase in the number of PARs since the last annual compliance review. The program's PAR rate during the annual compliance review period was .16, which is below the statewide Residential PAR rate of 1.51.

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

The program has a policy and procedures to satisfy pre-service training and certification requirements specified by Florida Administrative Code within 180 days of hiring a new staff. The program had twenty-three new staff members. A review of five staff training records indicated

staff completed an average of 137 pre-service training hours. The trainings and certifications included cardiopulmonary resuscitation (CPR), first aid, use of an automated external defibrillator (AED), Protective Action Response (PAR), ethics, suicide prevention, child abuse reporting, grievance process, Prison Rape Elimination Act, and behavior management. All instructors were qualified to deliver training the required training. All of the trainings were documented in the Department's Learning Management System (SkillPro). The program's training plan was submitted and approved by the Office of Staff Development and Training.

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

The program has a policy and procedures in place for staff to complete twenty-four hours of in-service training annually, including mandatory topics specified in the Florida Administrative Code. A review of five staff training records for annual trainings indicated each staff received training or re-certification for cardiopulmonary resuscitation (CPR), first aid, use of an automated external defibrillator (AED), Protective Action Response (PAR), ethics, suicide prevention, grievance process, emergency drills, and behavior management. Three of the five staff records reviewed for in-service training required eight hours of annual training related to management. The three staff met the requirement, averaging twelve hours of management training. All of the trainings were documented in the Department's Learning Management System (SkillPro). The program's training plan was submitted and approved by the Office of Staff Development and Training.

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

The program has a policy and procedures for the youth grievance process, which includes an informal, formal, and appeal phases. Grievance boxes and instructions for completing grievances are located on each living units and are accessible to all youth. The written interview of the facility administrator indicated knowledge of the grievance process. A review of five pre-service and five in-service training records indicated staff received training on the grievance process. The program maintains copies of grievances, at minimum, for twelve months. The program had a total of three grievances (denial of weekly phone call, youth written up for negative behavior, and missing shoes from a previous stay) in the last six months. All three grievances were reviewed. The three grievances had a staff response and documentation of the grievance being resolved. Five youth were interviewed. All of the youth said they understood the program's grievance process and staff will assist in completing grievance forms. Five staff members were interviewed about the grievance process and grievance training. All of the staff members said they understood and received training on the grievance process.

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

The program has a policy and procedures for delinquency intervention services. The program's delinquency interventions are Impact of Crime (IOC) and Thinking for a Change (T4C). The program director's written interview acknowledges the delivery of delinquency intervention services. The program has implemented delinquency intervention models recognized as evidence-based practice, promising practice, or a practice with demonstrated effectiveness. A review of the program's activity schedule showed the program provides structured, planned programming activities at least sixty percent of awake hours. A review of group sign-in sheets for the delinquency intervention groups indicated groups were delivered, as scheduled.

The program has policy and procedures for staff training on delinquency intervention services. Five staff facilitate delinquency intervention groups. Two of the interventions, T4C and IOC, require formal training. The facilitators for T4C and IOC received the required training and certifications. The therapists who facilitate Living in Balance are master's-level therapists and received supervision from the designated mental health clinical authority (DMHCA). The staff personnel records had documentation of appropriate education and work experience. The program director's interview indicated staff are selected to facilitate groups based on education and work experience.

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

The program has a policy and procedures ensuring life skills training is provided to program youth. The program's activity schedule listed daily life skills groups. A review of group sign-in sheets verified youth involvement and groups were delivered, as designed. Training records for two staff who facilitate life skills groups found they have the necessary training to facilitate the groups. Five youth records were reviewed, which showed youth are receiving life skills training, as outlined in their treatment and performance plans. Five interviewed youth reported they are learning to control impulse, coping skills, dealing with anger, non-violent conflict resolution, understanding substance abuse, critical thinking, and how to build positive goals as result of participating in life skills groups. The youth indicated they practice the skills learned in the groups. The youth said they are learning how to better control anger, better coping skills, and thinking before reacting.

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

The program has policy and procedures in place to provide restorative justice awareness activities or instruction to youth in the program. The program provides activities to increase youth awareness of, and empathy for, crime victims and survivors, and increase personal accountability criminal actions and harm to others. The program has one case manager trained to facilitate the Impact of Crime (IOC) curriculum. The program conducts IOC groups on Tuesdays and Thursdays for one hour. A review of sign-in sheets determined groups were delivered, as designed. Youth also participated in reparation through community service projects, such as rehabilitating dogs, feeding the homeless, a back to school drive/giveaway, lawn service for the elderly, and participating in a Breast Cancer Walk for a Cure and the annual Walk to end Diabetes. The walks were coordinate by the program's advisory board.

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

The program utilizes "Talks My Father Never had with Me: Helping the young male reach adulthood, Volume II" by author Dr. Harold Davis. The curriculum addresses the needs of the program's targeted gender group. A review of sign-in sheets determined groups were conducted weekly. The groups are facilitated by the facility administrator. A review of five Individual Healthcare Records found youth received gender-specific health education as well.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Limited 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 policy and procedures to determine how alerts are identified, documented, updated, and communicated to staff. Five interviewed staff indicated alerts are posted confidentially, inaccessible to youth, in the conference room, kitchen, and logbook. All alerts are discussed during staff meetings and as changes occur. Alerts are removed or downgraded by the appropriate staff. A review of the Department's Juvenile Justice Information System (JJIS) found two of three mental health alerts were updated late, with one late by eleven days and the second by fifty-one days. In addition, three of five alerts for escape (which were required to be entered upon admission and closed after thirty days) were never closed and/or updated. All JJIS alerts were also included on the program's internal alert system.

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 separate records for health, case management, and mental health services for each youth. Each record has the youth's name, Department identification (DJJID) number, date of birth, county of residence, and committing offense(s). Each case management record contains sections for legal information, demographic information, chronological information, correspondence, treatment activities, and miscellaneous. A review of five case management, health, and mental health records found all labeled "confidential." The records are secured in locked file cabinets and locked in offices.

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

The program has a formal process to promote constructive input by youth. The youth participate in the monthly town hall meetings and weekly student government meetings. A review of agendas, sign-in sheets, and minutes for the last six months indicated youth are given the opportunity to provide input into programming issues. All five youth interviewed said the program has a process in place to allow for youth input.

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

The program has a community advisory board which meets monthly. The board membership includes representatives from law enforcement, judiciary staff, community partners, local business owner, school board administrator, faith community, victim advocate, and one parent/guardian. The program maintains an advisory board binder with sign-in sheets, agendas, and minutes. The advisory board binder included letters from the facility administrator soliciting potential members. The binder also has letters to current board members reminding of upcoming meeting dates and other activities. Documentation reviewed found meetings were held, as required.

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

The program uses data, such as youth and parent/guardian surveys, the annual Quality Improvement report, and the Department's Comprehensive Accountability Report (CAR), to develop planning process. The program conducts daily and monthly meetings (daily shift change and monthly "all staff"). The management staff also meet daily. The program has improved/updated the training curriculum for all staff. The program provides staff incentives, such as monthly giveaways.

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

The program has a policy and procedures regarding staff evaluations. The program's evaluation of staff performance occurs after the first ninety-days of employment (probationary period), and annually (on the staff's anniversary of hire) thereafter. Staff promotions require a ninety-day probationary period. A review of five personnel records found each had job/positions, performance evaluations, and proof of education/experience. A review of five staff personnel records indicated three had ninety-days reviews, one an annual review, and one promotion review.

Standard 2: Assessment and Performance Plan

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

Five youth case management records were reviewed for initial contacts with the parent/guardian, committing court, juvenile probation officer (JPO), and post-residential services counselor (if applicable). Each record had documentation indicating the parent/guardian was contacted by telephone within twenty-four hours the youth's arrival. Each record also included written notification to the parent/guardian of the youth's arrival to the program within forty-eight hours of admission. All five records reflected program staff notified the committing court, JPO, and post-residential services counselor (as applicable) of each youth's arrival on the day of admission.

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

Five youth case management records were reviewed for youth orientation. Program orientation was documented in all records. Orientation included the following: services available to youth, expectations and responsibilities of youth, written behavioral management system, availability of and access to medical and mental health services, anticipated length of stay and expectations for release, physical design of the facility, Central Communications Center (CCC) and Florida Abuse Hotline access, contraband and consequences for having contraband items, performance plan process and goal development, hygiene and dress code, procedures for visitation, mail, and phone usage, access to the community, grievance process, fire drills, emergency and evacuation procedures, assignment to a living unit, and treatment team assignment. Five youth were interviewed, and all indicated the orientation process started within twenty-four hours of arrival.

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.	

Three of the five youth records reviewed were applicable for written consent of youth eighteen years or older. Each of the three records had documentation signed by the youth for consent to provide their information to other parties.

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

The program has a policy and procedures regarding the classification process, which addresses classification for room assignment and activities. The policy addresses youth safety, security, treatment services, and when reassessments are required. Five youth case management records were reviewed, and initial classification factors were documented in all five records. The initial classification documentation addressed each youth's physical characteristics such as height, weight, and physical stature. Also included were the youth's age, maturity level, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, the Department's Juvenile Justice Information System (JJIS) alert status, and special needs related to mental health, developmental, intellectual, and/or physical disabilities. An interview with the facility administrator indicated the therapist, case manager, and the clinical director review each youth's history prior to youth arrival. During intake, the treatment team takes into consideration the youth's presentation, age, and level of functioning before placing the youth on a living unit. All five reviewed records documented how the youth were assigned to a living unit/room based on the program classification system. Classification factors for activities included consideration medical issues, suicide risk, escape or security risk, increase in privileges, participation in work projects, and off-campus activities. The program utilizes an alert system, which provides staff updated classification information on each youth's alert status for medical, mental health, suicide, sexual aggression, and escape/security risks. Five youth records were reviewed for reassessment for activities. All five records had documentation of reclassification forms. Each youth had documentation of reclassification prior to a change in privileges.

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.	

None of the five youth records were applicable for youth with gang affiliation; therefore, two additional records were reviewed. Both youth were identified as gang members prior to admission. The records for both youth included copies of written notification to local law enforcement. Neither of the youth required notification of suspected gang activity. Notification to the educational provider, youth's juvenile probation officer, and post-residential counselor (if applicable) was accomplished prior to admission and documentation was found in the Department's Juvenile Justice Information System (JJIS).

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.	

None of the five youth records were applicable for youth with gang affiliation; therefore, two additional records were reviewed. The program utilizes screenings, assessments, the classification process, and the Department's Juvenile Justice Information System (JJIS) to help identify youth requiring participation in gang prevention or intervention activities. The program has an individual identified as a gang liaison and he/she is involved in the development and implementation of the program's gang preventions overall strategy. Documentation showed the two youth identified as gang members participated in individual counseling with their therapist to address issues related to gang identification, which was included in their performance plans. Both records included documentation indicating the youth were given a copy of Guide to Gangs at orientation as gang prevention.

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

The program has a policy and procedures to address the completion of Residential Positive Achievement Change Tool (R-PACT) assessments and reassessments for each youth. Five youth case management records were reviewed. Each of the five records included an initial R-PACT assessment completed in the Department's Juvenile Justice Information System (JJIS) within thirty days of the youth's admission. Each record included a hard copy of the initial R-PACT. Three youth records were applicable for R-PACT Reassessments, which included a total of five reassessments. Three of the R-PACT Reassessments were completed within the required ninety-day time frame. The remaining two reassessments were completed late, but by only three days in one record and seven days in the other. All reassessments were documented in JJIS and in the case management records.

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

The program has a policy and procedures to address the completion of a Youth Needs Assessment Summary (YNAS), requiring the completion of the YNAS within thirty days of admission. Five case management records were reviewed and all five contained a YNAS. Three assessments were completed within thirty days of admission to the program. One YNAS was completed four days late and one was completed two days late. Each YNAS was completed in the Department's Juvenile Justice Information System (JJIS) and maintained in the youth's case management record.

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

Five youth case management records were reviewed for performance plan development. Three of the records indicated performance plans were completed within thirty days of the youth's admission, as required. The remaining two performance plans were completed late, by two days in one record and twelve days in the other. All five plans were entered into the Department's Juvenile Justice Information System (JJIS) and completed after the Residential Positive Achievement Change Tool (R-PACT). Documentation in all of the records indicated treatment team members provided input for each youth's performance plan. Performance plan goals were measurable and included target completion dates, responsibilities of youth, and responsibilities for staff. The performance plans were signed by the treatment team leader, youth, and other parties who had responsibilities in the goal completion in four of the records. One plan did not have the signatures of the educational staff or living unit representative. All five performance plans included the top three criminogenic goals identified in the R-PACT. The original performance plans were in all five youth records and each record documented the youth received a copy of their performance plan. Five youth were interviewed, and all reported they participated in the development of their performance plan and they knew what goals they are working on.

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.	

Three of the five youth case management records reviewed were applicable for performance plan revisions. There was documentation in each record of the youth demonstrating progress toward completing the goals on their performance plans. Each youth's treatment team was involved in determining the need for performance plan revisions. Revisions to the individualized performance plans were made due to requiring based on youth's progress towards goals and for facilitation of transition activities during the last sixty days of the youth's stay.

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.*	

Three of the five youth case management records reviewed were applicable for performance summaries. The performance summaries addressed each youth's performance plan goals, behavior, academic status, peer interactions, interactions with staff, significant negative and positive events, overall treatment progress, and justification for release, as applicable. Two of the summaries were completed within ninety days and the remaining summary was completed three days late. Staff offered each youth an opportunity to add comments prior to adding their signature on the performance summaries. All performance summaries were signed by the treatment team leader, youth, and the facility administrator or designee. The performance summary transmittal letters were addressed to the juvenile probation officer (JPO) and parent/guardian, as required. All performance summaries reviewed were distributed within the required ten working days. In three closed records reviewed, release summaries were sent at least forty-five days prior to the youth's planned release. The original performance summaries and copies of release summaries were in each youth's record. None of the youth required victim notification.

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 five youth case management records found documentation demonstrating the program attempts to involve parents/guardians in the assessment, performance plan, and progress review processes. Parents/guardians were provided opportunities to attend or participate in these events. Parent/guardian contact and attempts to involve parents/guardians coincide with contract performance measures. An interview with the facility administrator indicated all parents/guardians are contacted by phone upon each youth's arrival, invited to participate in treatment team meetings, and encouraged to be involved with each youth through regular contact with program staff. All records reviewed also included copies of letters mailed to parents inviting them to participate in various events.

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

Five youth case management records were reviewed for treatment team members. Documentation indicated the treatment team included each youth, treatment team leader, an administration representative, living unit representative, educational staff, treatment staff, the

program's gang prevention specialist, and medical staff. None of the records required the involvement of the Department of Children and Families (DCF) caseworker or Agency for Persons with Disabilities (APD) staff. The juvenile probation officers (JPO) and parents/guardians participated by phone or contacts were attempted by telephone during treatment team meetings. Team members participated in or provided input for the treatment team meetings.

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

Five youth case management records were reviewed for incorporation of other plans into performance plans. Four of the five records documented the youth's academic plan was included in the performance plan. The fifth youth reviewed already had his GED prior to admission. All five of the reviewed records included a separate treatment plan for either substance abuse or mental health included in the performance plan. None of the records reviewed required Department of Children and Families (DCF) and/or Agency for Persons with Disabilities (APD).

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

Five youth case management records were reviewed for formal treatment teams. Formal treatment team review documentation included the youth's name, date of review, meeting attendees, input from team members, youth progress, performance plan revisions, youth's positive or negative behavior, any physical interventions, demonstration of skills acquired, treatment progress, and Residential Positive Achievement Change Tool (R-PACT) Reassessment results. Team members, the juvenile probation officer (JPO), and parent/guardian were invited and encouraged to participate for each youth's formal treatment team review. Formal treatment teams were conducted every thirty days with one exception. One formal treatment team was conducted six days late. A formal treatment team meeting was not observed due to no meetings being scheduled during annual compliance review week.

The five youth case management records were also reviewed for informal treatment team reviews. Each record contained informal treatment team review documentation which included the youth's name, review date, attendees, and input from team members. Informal treatment team review documentation included each youth's progress on performance plan goals, positive and negative behavior, treatment progress, and any physical interventions. The informal treatment team reviews included the youth and treatment team leader. Youth were provided an opportunity to demonstrate learned skills during informal treatment team review. The informal treatment teams were conducted as frequently as required with the exception of one week for

three youth at the end of March, for which the informal treatment teams were completed the next week.

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

A review of three closed records found each record included a completed employment application, a résumé, and documentation of the youth's parent/guardian and juvenile probation officer (JPO) being made aware of the vocational plan for the youth. The vocational program and career education is appropriate for the age and abilities of youth in the program, as well as the length of stay and custody characteristics for the program. The program offers a Type 2 program and includes communication, interpersonal, and decision-making skills. Two of three reviewed closed records documented an appointment calendar with Career Source and included documents essential to obtaining employment.

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.	

Duval County Public Schools provides educational instruction on a 250-day calendar to youth in the program. Classes are scheduled in four blocks to include 305 minutes of daily instruction time. Youth receive credits for the education and training received while at the program. The activity schedule and logbook documented minimal interference of education instruction. The interview with the lead teacher confirmed the education schedule and credits available.

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

Three closed records were reviewed for education transition plans. Each record included provisions for continuation of education and/or employment, a sample completed job application, a résumé, and documentation the youth's juvenile probation officer (JPO) and parent/guardian were aware of the plan. Each record also had an individual education transition plan developed based on the youth's post-release goals beginning at admission, to include all key personnel related to transition activities, responsibility requirements, and post-release needs.

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

Two of the five reviewed records were applicable for transition planning, transition conferences, and Community Re-Entry Team (CRT) meetings; therefore, one additional closed record was reviewed. The transition conference for each youth was completed at least sixty days prior to the youth's scheduled release date. The juvenile probation officer (JPO), treatment team leader, facility administrator, parent/guardian, education staff, and other pertinent parties were invited to participate in each youth's transition conference. The JPO and the parent/guardian participated by phone in the transition conference. The participants in the transition conference reviewed transition activities on the youth's performance plan, identified target completion dates, additional transition activities needed, and the person responsible for completion. Transition conference documents were signed and dated by the facility administrator or designee, youth, and team leader. Only one of the reviewed case management records was applicable for a CRT meeting. The CRT meeting was completed prior to the youth's release and the youth and case manager participated in the CRT. The case management record included a copy of the invitation to participate in 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.	

Two of the five reviewed records were applicable for exit portfolios; therefore, one additional closed record was reviewed. Documentation indicated the exit portfolio was discussed and initiated for all three youth during the transition conference. Two of the case management records included documents or reflected who was in possession of the following: identification card, calendar with appointments, Social Security card, certificates earned in the program, education records, résumé, sample job application, and birth certificate. One of the exit portfolios was in the process of gathering the above documentation, as the youth had recently entered transition. The exit portfolios were provided to the youth and juvenile probation officers (JPO).

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

Three closed youth case management records were reviewed for an exit conference. Exit conferences were conducted after notification to the juvenile probation officer (JPO) and at least fourteen days prior to the youth's anticipated release date. Documentation in each youth case management record reflected the JPO, parent/guardian, education representative, treatment team leader, and other pertinent parties were invited to participate in advance. The exit conferences were documented in each youth record and were separate from the transition and Community Re-Entry Team (CRT) meetings. The JPO and parent/guardian participation was accomplished by telephone.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor, who serves as the designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the State of Florida, which expires on March 31, 2021. A written interview provided by the DMHCA, or clinical director, indicated she is on-site forty hours each week and is on-call and available twenty-four hours a day. The clinical director communicates with administrative staff, therapists, case managers, and youth care workers. The clinical director reported the therapists' charts are reviewed weekly to ensure mental health and substance abuse services are delivered, as prescribed. The clinical director reviews progress notes daily to ensure the youth are receiving services on a daily basis. Documentation reflected the DMHCA or designee have been on-site at least forty hours each week. The DMHCA has been on leave since March 2019 and coverage has been provided by three licensed mental health counselors and two licensed clinical social workers. Each licensed clinical staff has a clear and active license in the State of Florida, with each license having an expiration date of March 31, 2021.

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

The program has one licensed mental health professional, who serves as the designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the State of Florida, with the license having an expiration date of March 31, 2021. Due to the DMHCA being on leave since March 2019, coverage has been provided by three licensed mental health counselors and two licensed clinical social workers. Each licensed clinical staff has a clear and active license in the State of Florida, with each license having an expiration date of March 31, 2021. Reviewed documentation and treatment records found licensed clinical staff provided services within the scope of their licensure, training, and education.

The program contracts with a psychiatrist, who is on-site weekly, to conduct psychiatric evaluations and provide medication management. The psychiatrist is board certified in child, adolescent, and adult psychiatry. The psychiatrist has a clear and active license to practice in the State of Florida, with a license expiration date of January 31, 2021.

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

The program has one non-licensed mental health and substance abuse clinical staff. The non-licensed staff has a master's degree in education with a specialization in mental health counseling. The non-licensed therapist completed twenty hours of training and supervised experience to conduct Assessments of Suicide Risk (ASR). The training included five supervised ASRs and the training was completed on March 14, 2017.

A review of clinical supervision logs for the past six months found the non-licensed clinical staff received at least one hour of clinical supervision each week by the designated mental health clinician authority (DMHCA) or a covering licensed mental health counselor. The direct clinical supervision was documented on a program form similar to the Department form MHSA 019, which included the date, start and end time of the supervision, the therapist's competency areas, discussion/focus areas, details of the supervision session, signatures of the non-licensed and licensed clinical staff, and the staff's credentials. Direct supervision was provided by the licensed clinical staff for the non-licensed clinical staff who conducted comprehensive mental health/substance abuse evaluations, initial mental health treatment plans, individualized mental health treatment plans, and Assessments of Suicide Risk (ASR), as evidenced by forms being signed by the licensed mental health clinical staff.

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

The program has a policy and procedures regarding a standardized screening process for mental health and substance abuse through the administration of the Massachusetts Youth Screening Instrument (MAYSI-2), Substance Abuse Subtle Screening Inventory (SASSI A-2), and a Beck Depression Inventory (BDI). The program has a policy and procedures indicating all youth, regardless of available information or MAYSI-2 findings, are referred for an Assessment of Suicide Risk (ASR) upon admission to be completed by the mental health clinical staff. The program's policy also indicates all youth are referred for a Comprehensive Bio-Psychosocial Evaluation to be completed within twenty-one days of admission.

Five youth mental health and substance abuse treatment records were reviewed for mental health and substance abuse admission screenings. Each record contained a MAYSI-2 completed on the youth's date of admission. Each MAYSI-2 was maintained in the Department's Juvenile Justice Information System (JJIS) and was completed by staff trained to conduct the MAYSI-2. Based on the MAYSI-2 results, three of five youth reviewed were identified in need of further assessment in the areas of alcohol/drug use, angry-irritable, depressed-anxious, somatic complaints, or thought disturbance. Each youth was referred utilizing a Mental Health Services Referral and MAYSI-2 Referral Form to be seen by the mental health department for further appropriate assessments. Each form documented the youth was referred during the intake process and the form identified if the youth was identified in need of further assessment

according to the MAYSI-2. Each record documented an ASR completed within twenty-four hours of admission. Each youth was also screened utilizing a Suicide Probability Scale (SPS) Manual, Beck Depression Inventory (BDI), and a Substance Abuse Subtle Screening Inventory (SASSI). Each record contained a Mental Health and Substance Abuse Screening Checklist, which documented a review of the pre-disposition report (PDR) regarding the youth's mental health and substance abuse history, the youth's Positive Achievement Change Tool (PACT), and the youth's medical record.

An interview with the facility administrator revealed youth are screened during intake for substance abuse, mental health, and suicide. The facility administrator reported the program utilizes various screenings tools such as the SPS, SASSI, and BDI which provide a raw score to implement into the formulation of the treatment plan and comprehensive assessment.

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

The program has a policy and procedures indicating all newly admitted youth are referred for a Comprehensive Bio-Psychosocial Evaluation to be completed within twenty-one calendar days of admission. Five mental health treatment records were reviewed for mental health and substance abuse assessments and evaluations. Each youth was referred for a mental health and substance abuse evaluation on the date of admission. Each youth received a new mental health and substance abuse comprehensive in-depth assessment within twenty-one calendar days of admission. Each comprehensive evaluation was signed by staff completing the evaluation and a licensed mental health professional on the date the evaluation was completed. Each evaluation contained the youth's identifying information, the reason for the evaluation, relevant background information, behavioral observations, a mental status examination, and the interview or procedures administered. Each evaluation contained a discussion of the findings, the diagnostic impressions, and recommendations. Each evaluation contained substance abuse information, including patterns of alcohol and other drug abuse, the impact of alcohol and other drug use on the major life areas, risk factors of continued alcohol or drug abuse, and strength/resiliency factors. Each record contained a signed consent for substance abuse services signed by the youth, staff member, and a witness.

The program has the required Chapter 397 licensure to provide outpatient substance abuse treatment services. The effective date of the license was September 1, 2018 and the license expires on August 31, 2019.

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

The program has a policy and procedures addressing mental health and substance abuse treatment and discharge planning. The policy outlines procedures for mental health treatment plans, substance abuse treatment plans, reviewing and updating treatment plans, transition or discontinuation of services, services and treatment, and mental health/substance abuse consents.

Five mental health and substance abuse treatment records were reviewed for mental health and substance abuse treatment. Each record contained a treatment team designation form confirming the youth was assigned to a treatment team upon admission. The designation form noted the various participants in treatment team to include the youth, case manager, therapist, clinical director, security supervisor, nurse, lead teacher, assistant facility administrator, and facility administrator. Treatment team documentation for each youth confirmed representatives from administration, education, medical, mental health/substance abuse clinical staff, and the parent/guardian, if available, participated in treatment team.

Two of the five records contained documentation showing youth received mental health and substance abuse treatment in accordance with each youth's individualized mental health and substance abuse treatment plan, to include daily group counseling. Three records contained documentation of daily group counseling with the exception of one day of group counseling not conducted in each record. Three records contained a properly executed Authority for Evaluation of Treatment (AET) and the remaining two records were for youth who were eighteen years of age. Each record contained a signed Substance Abuse Consent and Release form (Department form MHSA 012) and Youth Consent for Release of Substance Abuse Treatment Records (Department form MHSA 013). The mental health treatment notes were documented on a program form, which contained all the information on the Department's form MHSA 018. Group sign-in sheets for the past six months were reviewed, which confirmed mental health groups were limited to ten or fewer youth and substance abuse groups were limited to fifteen or fewer youth. Each youth received individual counseling at least once each month with the clinical mental health/substance abuse staff, and family counseling at least once a month, if applicable. One youth, who was eighteen years of age, opted out of family counseling. Each clinical staff member is qualified to provide mental health and substance abuse education.

Five interviewed youth reported they are participating in groups while at the program, to include life skills, anger management, and substance abuse. Four of five interviewed staff reported clinical staff facilitate mental health and substance abuse groups. An interview with the DMHCA indicated the clinical director facilitates groups and conducts individual counseling sessions as needed.

3.07 Treatment and Discharge Planning (Critical)	Satisfactory Compliance
Youth determined to have a serious mental disorder or substance abuse impairment, and are receiving mental health or substance abuse treatment in a program, shall have an initial or individualized mental health or substance abuse treatment plan. When mental health or substance abuse treatment is initiated, an initial or individualized mental health or substance abuse treatment plan is completed. *All youth who receive mental health and/or substance abuse treatment while in a residential program shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.*	

Five youth mental health and substance abuse treatment records were reviewed for treatment and discharge planning. Each record contained an initial treatment plan developed on the date of the youth's admission. Each initial mental health/substance abuse treatment plan contained the required elements included on the Department's form, MHSA 015. Each plan was signed by the treatment team members, the mental health/substance abuse clinical staff member completing the form, and the licensed mental health clinical supervisor within ten days of the plan's completion. Each record documented a copy of the initial treatment plan was mailed to the youth's parent/guardian for review, signature, and return to the program. Each plan documented each youth was referred for a psychiatric evaluation and medication management, if applicable.

Each youth's mental health and substance abuse treatment record contained an individualized treatment plan developed within thirty days of the youth's admission, and initiation of treatment. Each individualized treatment plan was completed on a form with all the required elements of the Department's form MHSA 016. Each plan was signed by the youth, case manager, treatment team members, mental health/substance abuse clinical staff, and the licensed clinical supervisor within ten days of the plan's completion. Each individualized treatment plan was mailed to the youth's parent/guardian for review, signature, and return to the program. One record contained a plan signed by the youth's parent/guardian. At the time of the development of the individualized treatment plan, one of the five youth were prescribed psychotropic medication and the youth's record included a Clinical Psychotropic Progress Note (CPPN) documenting the psychiatric medication and the frequency of monitoring. Two youth were prescribed psychotropic medication subsequent to admission and an addendum to the individualized treatment plan was completed, which included the medication information and frequency of medication monitoring by the psychiatrist. Each individualized treatment plan was completed on a program form which contained of the required elements of the Department's form, MHSA 017, and prescribed services for the youth to include individual, group, and family counseling. Each record documented monthly treatment team reviews.

Three closed mental health and substance abuse treatment records were reviewed for discharge planning. Each record contained a mental health/substance abuse discharge plan documented on the Department's form MHSA 011 Treatment Discharge Summary. None of the reviewed records indicated the youth was applicable for notification of suicide risk/precautions at the time of discharge. Each discharge summary identified services needed for daily maintenance of the youth's skills learned during treatment. Each discharge plan was discussed during the exit conference, and a copy of the Mental Health/Substance Abuse Treatment Discharge Summary was emailed to the youth's juvenile probation officer (JPO). Two of three records documented the discharge summary was provided to the parent/guardian at the time of

the youth's discharge, with the remaining record documenting the plan was provided to an eighteen-year-old youth who was transported back to his home county via the Department's intrastate transportation. Each record documented the youth was provided a copy of the discharge plan.

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 substance abuse overlay services and has a bed capacity of twenty-eight male youth. Substance abuse services are provided daily by the mental health clinical department. A review of group sign-in sheets confirmed the program provides substance abuse treatment services and group treatment is provided daily. An interview with the facility administrator indicated the program also participates in equine therapy at the Haven Horse Ranch in St. Augustine, Florida. The facility administrator also reported the program added a dog program called TAILS on January 3, 2018.

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

The program has a policy and procedures outlining psychiatric services for youth, to include psychiatric evaluations, psychiatric consultation, medication management, and medical supportive counseling. The facility operating procedures related to mental health and substance abuse were signed by the psychiatrist, to include an annual review within the last year.

The program contracts with a psychiatrist, who is on-site weekly to conduct evaluations and medication management. The psychiatrist is board certified in child, adolescent, and adult psychiatry. The psychiatrist has a clear and active license in the State of Florida with an expiration date of January 31, 2021. The contract with the psychiatrist was signed on March 4, 2019 and commenced on March 20, 2019. According to the contract, it is in effect through and including March 19, 2020, unless terminated early and it will automatically be renewed for successive periods of one year. The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. A review of sign-in logs documented the psychiatrist was on-site once a week.

A review of five mental health and substance abuse treatment records reflected each youth was referred for a psychiatric evaluation and was assessed by the psychiatrist within fourteen days of the referral. Each psychiatric evaluation was a new assessment, which included the youth's medical, mental health, and substance abuse history, a mental status examination, diagnosis, and treatment recommendations. One of five youth were applicable for entering the program on psychotropic medication and two youth were prescribed psychotropic medication subsequent to admission. Each psychiatric evaluation included the prescribed medication, the diagnosis, target symptoms, potential side effects, risk and benefits of taking the medication, and the frequency of medication monitoring on the Clinical Psychotropic Progress Note (CPPN). Each of the three applicable records documented a witness signature of the parent/guardian's verbal consent for

medication changes. Each applicable record reflected medication management was conducted with the psychiatrist at a minimum of every thirty days. An interview with the psychiatrist indicated the psychiatrist's role in the coordination and implementation of psychiatric services includes conducting evaluations and medication management. The psychiatrist reported he conducts face-to-face or telephonic communication with representatives of the program's treatment team on a weekly basis. Documentation reflected the psychiatrist signed the monthly mental health/substance abuse treatment plans for the three youth taking psychotropic medications. Documentation reflected the program does not have standing orders or emergency treatment orders for psychotropic medications.

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

The program has a policy and procedures addressing a suicide prevention plan, which was signed by the facility administrator and designated mental health clinician authority (DMHCA) on March 5, 2019. The suicide prevention plan includes the identification and assessment of youth at risk of suicide during the admission process and during their length of stay, staff training, suicide precautions, levels of supervision, and the referral process. The plan also includes the steps for communication, notification, documentation, immediate staff response, review process, the alert process, and safe housing areas within the program. An interview with the facility administrator indicated the program conducts mock drills to include an emergency response to a suicide attempt or self-inflicted injury on a quarterly basis. Documentation of mock suicide drills confirmed they were conducted on each shift on a quarterly basis.

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.*	

Five youth mental health and substance abuse treatment records were reviewed for suicide prevention services. None of the records reviewed were applicable; therefore, three incidents of youth determined to be at risk of suicide were reviewed. Each youth was placed on precautionary observation due to a self-report or staff observations. Each record documented an Assessment of Suicide Risk (ASR) was completed on the date the youth was determined to be at risk of suicide. Each ASR was completed on the Department's form MHSA 004. The initial ASR in each record determined the youth would remain on constant supervision. Each record contained a Follow-up ASR placing the youth onto close supervision and a second Follow-Up ASR placing the youth on standard supervision. Each ASR and Follow-up ASR was completed by a licensed mental health clinician or a non-licensed mental health clinician who completed the required training. Each ASR documented a conference was held with the licensed mental

health professional and the facility administrator or designee prior to reducing the youth's supervision level. Each ASR was signed by the mental health clinical staff completing the ASR, the licensed mental health staff, and facility administrator. The ASRs documented contact was made with the parent/guardian and juvenile probation officer to notify them of the youth's potential suicide risk, as indicated by the ASR. Each record contained a suicide precaution observation log. Each of the three incidents contained an observation log with lapses in the observations exceeding the thirty-minute intervals (these exceptions are scored under Indicator 3.12). A review of the Department's Juvenile Justice Information System (JJIS) reflected alerts were entered when the youth was identified as being a suicide risk. One alert was closed immediately when the youth was placed on standard supervision. One alert was closed eleven days after the youth was removed suicide precautions and one alert was closed fifty-one days after the youth was removed from suicide precautions. The facility logbook documented each youth was placed on constant supervision; however, only two records documented the youth's placement on close supervision and standard supervision. The logbook did not document two of the instances when the youth was transitioned from close supervision to standard supervision (the exceptions related to alerts in JJIS and the logbook are scored under Indicator 1.14)

The program maintains a suicide response kits, which include a knife for life, wire cutters, and needle nose pliers, in each of the two module sub controls and master control. The program maintains an alert board for staff to pass on information related to suicide precautions. The program has a policy and procedures, which includes a review process for all critical incidents at the program. The policy indicates all critical incidents are to be reviewed by the facility administrator, assistant facility administrator, and the designated mental health clinician authority (DMHCA). The policy addressed the circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, and the possible precipitating factors. The policy addresses recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

Five interviewed staff reported if a youth expresses suicidal thoughts, they are responsible for notifying mental health staff. In addition, four staff members reported they document supervision, and three staff members reported the youth is placed on constant sight and sound. Four staff members reported the suicide response kit is maintained in master control and in sub-control.

3.12 Suicide Precaution Observation Logs (Critical)	**Failed 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.	

None of the records reviewed were applicable for youth on suicide precautions; therefore, three additional records were reviewed for suicide precaution observation logs. Each suicide precaution observation log was maintained for the duration the youth was on suicide precautions, with one exception where a log was started ten minutes after the youth was placed on suicide precaution. Two of the three logs documented warning signs, and in each instance, the clinical director was notified and the youth was subsequently Baker Acted. Each precautionary observation log reflected lapses in observations. One log documented an hour between observations, with four additional instances of late checks documented between thirty-one and thirty-two minutes. One suicide precaution log had a lapse of four hours with no

observations documented. The remaining suicide precaution log documented thirty-five minutes between two observations. The log also documented checks were conducted at 5:10 p.m. and at 5:35 p.m.; however, the next set of checks documented were conducted at 5:15 p.m. and 5:45 p.m. The suicide precaution observation logs were signed by the supervisor; however, one log was signed by the supervisor thirteen-and-a-half hours before the observation log and checks were completed. Each log was signed by the mental health clinical staff and documented safe housing requirements. There were several instances on the precaution observation logs of times being written over.

Three youth who were placed on precautionary observation were interviewed and each reported they were with staff at all times while on suicide precautions and were not left alone for any period of time. One of the three youth reported they were on one-to-one supervision, stepped down to close supervision, and then to standard supervision. Two additional youth were interviewed, and each reported they were not aware they were on suicide precautions, but they are not left alone.

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

The program has a policy and procedures outlining mental health and medical drills. The policy indicates mental health drills are initiated by the clinical director and are to be conducted on each shift quarterly.

Documentation reflected the program conducted mock suicide drills at least once each quarter, on each of the two shifts. Emergency medical drills were conducted on a monthly basis on each of the two shifts as well. A review of the mock drills compared to the staff roster reflected twenty of twenty-one applicable staff participated in at least one quarterly mock suicide drill semi-annually. Documentation reflected mock emergency drills conducted on each shift included a cardiopulmonary resuscitation (CPR) demonstration at least once each quarter. The mock suicide drills documented actions taken by staff included using the radio to call for back-up support, medical personnel, and emergency medical services (9-1-1), as well as utilizing CPR and the suicide response kit. The program reviews the drills in staff meetings for staff members who are not present during the mock drills to review the drill scenario and procedures. A review of five pre-service and five in-service staff training records reflected each staff member completed at least six hours of suicide prevention training, to include two hours of training in the Department's Learning Management System (Skill Pro) and four hours of instructor led training.

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

The program has a policy and procedures addressing the program's crisis intervention plan, which is separate from the program's emergency mental health and substance abuse plan. The plan was signed by the facility administrator and designated mental health clinician authority

(DMHCA) on March 5, 2019. The crisis intervention plan addresses a notification and alert system, means of referral, including a youth self-referral, communication, and supervision to include one-to-one, close, and standard supervision. The plan also includes procedures for documentation, review, follow-up mental status examinations, and mental health supportive services. The plan contains an emergency notification list, which includes contact information for the clinical director, designated health authority, facility administrator, assistant facility administrator, and the Jacksonville Sheriff's Office.

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 did not conduct a crisis assessment during the annual compliance review period. The program provided a copy of the crisis assessment tool to be utilized in the event one is needed. The crisis assessment form includes identifying information, the reason for the assessment, the method of assessment, a mental status examination, a determination of danger the youth presents to themselves or others to include the imminence of behavior, intent of behavior, clarity of danger, and lethality of behavior. The crisis assessment form also includes the initial clinical impression, supervision recommendations, treatment recommendations, and recommendations for follow-up or further evaluation. The crisis assessment form has a section for notifications to document contacts with the parent/guardian, juvenile probation officer, and outside provider, if applicable. The form is to be signed, dated, and document the time the form was completed by the mental health clinical staff person, a review of the licensed mental health professional, and the facility administrator or designee. The form includes a section to be completed after the follow-up mental status examination to identify a change in supervision. The program has a policy and procedures stating a mental health alert is to be entered into the Department's Juvenile Justice Information System (JJIS) for any youth placed on precautions after the completion of a crisis assessment and the youth is to remain on alert until the follow-up mental status examination is completed. The policy indicates if a youth is taken off-site for a crisis assessment, the youth is to be maintained on constant supervision upon return to the program until a mental health clinical staff person conducts a follow-up assessment.

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

The program has a policy and procedures outlining an emergency mental health and substance abuse plan, which is separate from the program's crisis intervention plan. The plan was signed by the facility administrator and designated mental health clinician authority (DMHCA) on March

5, 2019. The plan includes the immediate staff response, notifications, communication, supervision, and authorization to transport for emergency mental health or substance abuse services. The plan also includes transportation for an emergency mental health evaluation and treatment under Chapter 394 for a Baker Act, and transportation for an emergency substance abuse assessment and treatment under Chapter 397 for a Marchman Act. The plan also includes procedures for documentation, training, and a review process.

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

During the annual compliance review period, the program had one youth who received Baker Act services in September 2018. In each instance, the youth was determined to be in need of emergency care and was placed on constant supervision. The clinical director was contacted and completed a Certificate of Professional Initiating Involuntary Examination for each incident. Local law enforcement was contacted to transport each youth for an emergency mental health evaluation and treatment under Chapter 394 for a Baker Act. Upon return to the program from the Baker Act, the youth was placed on constant supervision upon re-admission. A Follow-up Assessment of Suicide Risk (ASR) was completed and the ASR documented a conference was conducted with the licensed mental health professional and the facility administrator or designee. In each instance the youth was transitioned to close supervision and another Follow-Up ASR transitioned the youth to standard supervision. Each ASR was signed by the staff conducting the assessment, the licensed mental health professional, and the facility administrator or designee. The program did not utilize a Marchman Act during the annual compliance review period.

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.	

There is a contract in place with a licensed medical doctor (MD) to serve as the designated health authority (DHA). The DHA has specialty training in internal medicine and experience in providing care for adolescents. The MD has a clear and active license in the State of Florida with a license expiration date of January 31, 2020. The DHA is to be on-site at least two hours a week and available for consult twenty-four hours a day, seven days a week. The contract outlines services to be provided. Sign-in logs showed the DHA has been on-site weekly for the past six months with minor exceptions. There were three instances of ten days between DHA visits. An internal audit completed by the provider identified these three visits being a day late and a corrective action plan was implemented. There have been no late visits since the corrective action plan was put in place. An interview with the DHA and review of five youth records and other documentation confirmed the DHA provides oversight for all healthcare provided for youth at the program.

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

Medical policies, procedures, and protocols were reviewed and signed by the designated health authority (DHA) and facility administrator in February 2019. Each individual policy and procedure was signed by the DHA and the facility administrator. Nursing staff signed an acknowledgement of the medical policies and procedures and nursing protocols within the past year. The psychiatrist signed policies and procedures related to psychiatric care and psychotropic medication monitoring. The program had one new nurse hired during the annual compliance review period. The new nurse completed an orientation and on-the-job training for health services provided at the program.

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.	

Five youth Individual Healthcare Records were reviewed for Authority for Evaluation and Treatment (AET) forms. Two youth were eighteen years old at the time of admission and did not require an AET. The three applicable records contained a valid AET signed by a parent/guardian. Each AET was a copy and appropriately labeled as a copy. Two additional records were reviewed for youth in the care of the Department of Children and Families (DCF). A court order authorizing care was on file for each DCF youth. The interview with the nurse showed she was familiar with the process of obtaining an AET.

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

Five individual youth healthcare records were reviewed for parental notifications. Four records were applicable for off site care (all had dental appointments) and parental notifications were documented in each record. Additional records were requested and reviewed for parental notifications for medications and emergency transports. The records and a sick call observed found parents/guardians were called when new medications were prescribed or when over-the-counter (OTC) medications were given in accordance with standing orders. Documentation showed the telephone notifications were witnessed by other staff members. The phone notifications were followed by written parental notifications each time a new medication was started. Two youth were taken to the emergency room. Documentation showed one parent/guardian was contracted by phone when her son was transported to the emergency room. In the remaining record, documentation showed multiple phone attempts were made to contact the parent/guardian. Written notifications were completed in each record.

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

Three of the five Individual Healthcare Records reviewed were applicable for youth taking psychotropic medication. Each youth was prescribed new psychotropic medication and one youth had a psychotropic medication discontinued. Verbal consent from the parent/guardian was documented by the psychiatrist and witnessed by a nurse each time psychotropic medication was started, adjusted, or discontinued. An Acknowledgement of Receipt of Clinical Psychotropic Progress Note (CPPN) along with page three of the CPPN was sent to the parent/guardian as well. Notifications were sent along with page three of the CPPN for monthly medication monitoring as well. Psychotropic medications were not started until consent from the parent/guardian was documented, which was confirmed in records reviewed. The interview with the nurse confirmed consent is required prior to initiating new psychotropic medication. The nurse also knew notification requirements for when psychotropic medications are adjusted or discontinued.

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

The program has a policy and procedures addressing immunizations for youth when the need is identified. Youth are sent to the health department for immunizations when needed. A review of five youth Individual Healthcare Records found immunizations were reviewed by nursing staff upon admission in each record. The initial progress note completed by the nurse conducting the medical intake indicated each youth's immunizations were current. The nurse reported none of the youth have needed immunizations during annual compliance review period.

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

Five youth Individual Healthcare Records were reviewed for the completion of Facility Entry Physical Health Screening (FEPHS) forms. A FEPHS form was completed by a nurse on the date of admission in each record. All sections of the FEPHS form and the body chart were thoroughly completed. The nurse was interviewed and confirmed the process for the completion of the FEPHS forms at the time of admission.

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

The program maintains a cabinet in administration, which contains an alert board. The alert board identifies different alerts with colored push pins, with different colors representing different alerts. There is also an alert log, which reflects each youth's medical grade, medication restrictions, dietary restrictions, allergies, physical limitations, medication side effects, and types of alerts. A review of five youth records, the alert board, and alert log found medical alerts were accurately reflected on the alert board and alert log. Youth alerts were also reflected on the Problem Lists found in the records. The nurse was interviewed and reported only nursing staff can update medical alerts. Five staff were interviewed. Each staff reported they review the alert board during their debriefing prior to each shift.

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

Five youth Individual Healthcare Records were reviewed. Documentation on forms developed to address specific healthcare orientation topics and Health Education Records showed all required topics were addressed during the healthcare orientation. The forms addressed how to access sick call, medical emergencies, medication administration, and instructions to notify staff of any chest pain, shortness of breath, or other similar difficulties. Youth are also informed of what to do in the event of a sexual assault or attempted sexual assault, the right to refuse care, and the non-disciplinary role of healthcare staff. The orientation forms were signed by each youth and the nurse providing the orientation.

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

A review of five youth healthcare records found the designated health authority (DHA) and psychiatrist were notified of each youth's admission, as it is the program's practice to notify the DHA and psychiatrist of each youth's admission, regardless of their condition(s). The notifications were completed by phone or fax by the nurse conducting the medical intake. The notifications were documented in the initial progress note and a separate form developed for the

notifications. The notifications identified medical and mental health conditions, to include chronic conditions, as well as identified if the youth was taking medication(s).

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

The nurse reported there have not been any youth with a change in custody during the annual compliance review period. The program has a policy and procedures requiring the completion of an admission healthcare screening anytime a youth has a change in custody and returns to the facility. The interview with the nurse revealed she knew the policy.

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

Five youth healthcare records were reviewed for a Health-Related History (HRH) form. A new HRH form was completed by a registered nurse on the date of admission in each case. The interview with the nurse confirmed this practice. The designated health authority (DHA) reviewed the HRH form prior to the completion of the Comprehensive Physical Assessment (CPA), which was documented on the HRH form and CPA in each case.

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

Five youth healthcare records were reviewed for a Comprehensive Physical Assessment (CPA). The program's practice is to complete a new CPA on each youth, even if a current CPA is available in the commitment packet. Each record contained a current CPA in the commitment packet, as well as, a new CPA completed at the program within seven days by the designated health authority (DHA). For the new CPAs completed at the program by the DHA, all sections were addressed and documented in accordance with Department requirements. Refusals of any part of the exam were appropriately documented by youth signature and youth initials in the box for the part of the exam being refused. An interview with the nurse indicated a new CPA is completed on each youth upon admission and CPAs are updated annually.

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

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

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

Five youth Individual Healthcare Records were reviewed for tuberculosis screening. The date of a current tuberculosis screening test (TST) completed prior to admission and the results were documented on the Comprehensive Physical Assessment (CPA) and Infectious Communicable Disease (ICD) form in each record. Two youth had an annual update to the TST after admission, which was completed and documented on the ICD form in each case. The interview with the nurse revealed she knew the requirements for a current TST at admission and she reported the program completes a new TST for youth annually.

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

A review of five youth healthcare records found a Sexually Transmitted Infection (STI) Screening form was completed by a registered nurse (RN) on the day of admission in each case. The STI Screening was reviewed and signed by the designated health authority (DHA) within a week of admission. The regular admission orders by the DHA include STI testing if requested by the youth. Testing was ordered and performed on each youth. The STI testing results were documented on the Infectious Communicable Disease (ICD) form and filed in the lab section of each record. The nurse interview revealed she was familiar with STI screening requirements.

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

Human immunodeficiency virus (HIV) testing is provided by River Region, which comes to the program to offer and complete testing. Five youth healthcare records were reviewed and documented each youth was offered testing upon admission. Three youth consented to HIV testing and were tested. Pre-test and post-test counseling were documented on the Health Education Record for each youth. Test results were appropriately filed in each youth's healthcare record in a sealed envelope marked confidential. The nurse was interviewed and was able to explain how HIV services are provided at the program. All five youth interviewed said they could ask for a HIV test.

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

Sick call is conducted twice a day between 9:00 a.m. to 11:00 a.m. and 2:00 p.m. to 4:00 p.m. Sick call request forms are available to youth in the large multi-purpose room, or pavilion. Youth complete sick call request forms and place them in a secured box. Nursing staff retrieve the sick call requests from the boxes twice daily. None of the youth presented with a similar complaint three times in a two-week period, though three were referred to the designated health authority due to the nature of their complaint(s). None of the youth made a complaint with which staff

were unfamiliar. Supervisors address youth complaints if nurses are not on-site and will contact the nurse, if necessary. The interview with the nurse confirmed the frequency of sick call, the process for youth completing sick call forms, and nursing staff checking the sick call boxes.

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

Five youth healthcare records were reviewed, which included twenty sick call encounters. Each sick call was completed by a registered nurse. All sick calls were documented in the SOAP (subjective, objective, assessment, and plan) format and reflected required elements, such as vital signs, education, and care provided. Youth were provided with instructions and follow-up care was provided, as needed. The sick call forms were signed by the nurse providing the care and the youth. All sick calls were documented in the sick call log and on individual youth sick call index forms. A sick call for one youth was observed; the youth consented to this observation. The sick call was conducted in private, with a curtain being pulled to cover the hallway leading to the exam room. The nurse completing the sick call completed a general assessment of the youth and thoroughly addressed the youth's issue. The care to be provided was explained to the youth and the nurse instructed the youth to return if his issue continued or worsened.

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

The program's policy, procedure, or contract states they do not use restricted housing; therefore, this indicator rates as non-applicable.

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

Seven instances of episodic care were reviewed. All instances of episodic care were completed and properly documented by licensed medical staff in the SOAP (subjective, objective, assessment, and plan) format. All seven instances of episodic care were documented in the episodic care log.

First aid kits are kept in each sub control, the kitchen, and in master control, which included kits for each vehicle. The designated health authority (DHA) has identified and approved required contents for the first aid kits. All first aid kits observed were fully stocked with items approved by the DHA. The kits are secured with breakaway tabs, so is it known when kits are opened and supplies are taken. Supplies are restocked whenever items are used or when they expire. Nursing documented weekly checks of all first aid kits to ensure all required contents were present and within date.

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

Training records for ten direct care staff and nursing staff showed all held current certifications in first aid, cardiopulmonary resuscitation (CPR), and use of an automated external defibrillator (AED). Documentation of medical drills showed medical drills were conducted monthly on each shift. The drills included a CPR demonstration at least once a quarter. The drills were properly documented, reflecting staff present, actions taken by staff, and a critique or corrective actions needed. Two instances of youth being taken to the emergency room were reviewed. Staff responded appropriately in each case and there was appropriate follow-up by medical staff.

The program has one AED, which is kept in the pavilion. The battery for the AED is good through November 2022 and the pads are good through July 2019. The AED is checked weekly by nursing, which includes a review of expiration dates for the battery and pads. The nurse completed a test of the AED in front of the annual compliance review team, showing it was ready for use. A list of emergency numbers is kept in the cabinet with the alert board. Five direct care staff were interviewed, and all reported they were authorized to call 9-1-1 in the event of a medical emergency. The nurse was interviewed and able to explain the program's emergency care procedures and practices.

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

Four youth Individual Healthcare Records reviewed were applicable for off-site care. A summary of off-site care form was completed in each record. Discharge paperwork from the provider was attached to the summary in each record. The discharge paperwork was reviewed and signed by the designated health authority (DHA). Follow-up appointments and referrals were tracked and scheduled by nursing staff, as needed.

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

Three applicable youth Individual Healthcare Records for youth with chronic conditions were reviewed. All three youth were placed on the chronic conditions list and the internal medical alert board and form. An initial assessment was completed by the DHA to address the chronic condition in each record. Periodic evaluations were scheduled and completed at or within ninety-day intervals, as applicable. The interview with the DHA and review of the program's policy and procedures indicated youth with chronic conditions will have periodic evaluations every three months.

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

Three applicable youth Individual Healthcare Records for youth who entered the program with medication were reviewed. All youth were in a Department detention center prior to being transported to the program by detention staff. Nursing staff at the program received the medication(s) and documented verification in the healthcare record. The designated health authority (DHA) and psychiatrist were informed of the medication in each case. Each youth continued to receive their medication(s) as prescribed following admission.

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

Five youth Individual Healthcare Records were reviewed for medication management. Each youth was on medication at some point during their stay. Current, valid medication orders were in place for each prescription medication and over-the-counter (OTC) medication to be taken on a regular basis. Medication orders were updated whenever medication monitoring or chronic condition evaluations occurred. Youth admitted with medication continued the medication in accordance with the order.

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

All medications are stored in the medical clinic. All active medications, to include all prescription and controlled medications, are stored in a secured medication cart. Controlled medications are double locked, stored in a locked box within the secured medication cart. Medications were stored separately by type (oral, topical, nasal sprays, injectable, and eye drops) and by youth. Over-the-counter stock medications are stored in a secured cabinet. There is separate refrigerator for medication requiring refrigeration. All medication storage was clean and organized. Sharps are secured in the cart and a locked cabinet.

The program has a policy and procedures in place for the disposal of controlled medications and to return unused non-controlled medications to the pharmacy for credit or disposal. The program has a modified Institutional Class II Type B pharmacy permit, for which a consultant pharmacist visits the program monthly. Documentation showed the consultant pharmacist disposes of controlled medication on-site, which is witnessed by the nurse on site.

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

The program maintains working and bulk supplies of over-the-counter (OTC) medications. Documentation showed the bulk supply of OTC medication is inventoried at least weekly and perpetually when the active supply is replenished. Documentation showed the working supply of OTC medications are inventoried daily. Documentation showed sharps are inventoried at least

weekly and perpetually when sharps are used. Three active OTC medications, three bulk supply OTC medications, two prescribed controlled medications, and three sharps were counted in the presence of a member of the annual compliance review team. The counts for each medication and sharp matched the ending inventory. The program has a process in place to correct and report inventory discrepancies.

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

The program has a policy and procedures to address controlled medications. All controlled medications are kept in a locked box in the secured medication cart, securing them in a double-lock system. Two youth were on controlled medications at the time of the annual compliance review. Each controlled medication inventory was reviewed, finding the inventories were documented perpetually when the medications were administered and for each nursing shift. There were two signatures for the shift-to-shift inventories, which included at least one nurse signature. The two controlled medications were counted in the presence of a member of the review team, which confirmed the controlled medication inventory forms were accurate.

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

Medication Administration Records (MARs) were present for each youth. The MARs were completed by month, with MARs including prescription medication and over-the-counter (OTC) medications given based on standing orders. The standard Department MAR is used. Each MAR included all required information, to include the youth's name, Department identification number, date of birth, allergies, precautions, and medical grade. A picture of each youth is maintained with their MAR in a notebook containing all the MARs for the month. Start and stop dates were documented for each medication, with the dates being updated or corrected by hand when orders were updated. Monitoring for side effects was documented weekly on a separate form. Observation of medication administration revealed the nurse asked each youth about side effects when giving them their medication.

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

A review of Medication Administration Records (MARs) showed licensed healthcare staff appropriately documented medication administration, to include refusals. Policy and procedures state only medical staff may administer parenteral medication or assist youth in self-administration of parenteral medication.

An evening medication administration was observed during the annual compliance review. The nurse's working space was clean and organized. The nurse conducting the medication administration maintained control of the medication cart and the medication containers. Each youth approached the nurse one at a time for their medication and, as they approached, the

nurse asked each youth to provide their name and date of birth. Prior to each medication being administered, the nurse verified the time, medication, and the medication dosage with the youth. The nurse asked each youth if they have any medication allergies and if they were experiencing any side effects to the medication. Immediately after taking their medication, the nurse and the direct care staff checked each youth's mouth to ensure the medication was swallowed. The prescription medications were not pre-poured. The nurse signed the youth's Medication Administration Record (MAR) after each medication was administered.

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

The program has six non-healthcare staff who have been trained in medication administration. A list of the non-healthcare staff trained in medication administration is maintained. These staff acknowledged treatment protocols, which included administration of over-the-counter medication for minor conditions. A review of Medication Administration Records (MAR) showed non-healthcare staff properly documented medication administration with one exception. For the one exception, the staff documented his/her initials on the MAR but did not have the youth record his initials on the MAR.

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

The program's practice is to complete a psychiatric evaluation on each youth admitted to the program. The evaluations are recorded on a form used by the psychiatrist and page three of the Department's Clinical Psychotropic Progress Note (CPPN), with psychotropic medication(s) information documented on page three of the CPPN. The evaluations include all required elements, to include identifying data, youth history, current or previous medications, and diagnosis. There were no emergency orders or standing orders for psychiatric care.

Five youth Individual Healthcare Records were reviewed. A psychiatric evaluation was completed on each youth within fourteen days of admission. One youth was admitted with psychotropic medication and two youth were placed on psychotropic medication after admission. The youth admitted with psychotropic medication had adjustments made to his medication and was prescribed a new psychotropic medication. Monthly psychotropic medication monitoring was documented by the psychiatrist for all three applicable youth. All required information was documented on the CPPN for each monthly monitoring, including the initiation of new psychotropic medication, adjustments or discontinuations of existing medications, targeted symptoms, and side effects. Documentation showed new psychotropic medications were not started until parental consent was received.

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

The program has infection control policies and procedures in place. The procedures address prevention, containment, treatment, and reporting requirements related to infectious diseases in accordance with Occupational Safety Health Administration (OSHA) federal regulations and Centers for Disease Control and Prevention (CDC) guidelines. Infectious diseases addressed in the procedures include common self-limiting illnesses, common contagious illnesses, serious infectious diseases, Hepatitis A, B, and C, lice, scabies, methicillin-resistant staphylococcus aureus (MRSA), foodborne illnesses, bio-terrorism agents, chemical exposure, and other conditions caused by any other infectious agents. The procedures outline potential exposure for employees and staff are offered a Hepatitis B vaccine when hired. The procedures also address access to personal protection equipment. The designated health authority (DHA) reviewed the infection control procedures and exposure control plan in January 2019.

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

Five youth Individual Healthcare Records were reviewed. Each record documented the youth received infection control training on hand-washing techniques, standard precautions, prevention/transmission of communicable diseases, vaccinations, and Center for Disease Control guidelines for infection control. A review of ten staff training records revealed all staff received training in infection control, which was provided by a licensed medical professional.

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

The program's exposure control plan was written in accordance with the Occupational Safety Health Administration (OSHA) standards. The plan was signed by the designated health authority (DHA) and facility administrator in January 2019. The plan is available to all staff. The plan outlines risk assessment, methods of compliance, and processes for needle stick post-exposure evaluation. There have not been any instances of exposure requiring notification of the Department of Health or Centers for Disease Control and Prevention (CDC). The interview with the facility administrator indicated program's exposure control plan is available to staff in the clinic and reviewed with staff monthly.

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

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

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

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

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

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

Standard 5: Safety and Security

5.01 Youth Supervision	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. The staff-to-youth ratios required by contract for the program are one staff for every eight youth during awake hours, one staff for every twelve youth during sleep hours, and one staff for every five youth for off-campus activities. Observations of staff supervision of youth were made several times during the annual compliance review, which included movements, meals, school, outside recreation, and when youth were in their dorms. Staff were observed to be appropriately positioned to supervise youth, maintained active supervision of youth, and interacted with youth in a professional manner. The required staff-to-youth ratio was actively maintained at all times. Staff were aware of the number of youth under their supervision. Youth head counts were observed, resulting in an accurate count each time. Procedures are in place to reconcile head counts, if needed.

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

The program has a policy and procedures outlining the program's behavior management system (BMS). The program utilizes a four-level BMS with identified time frames for each level. The BMS indicates if the youth's behavior does not show progress or warrant progress, the youth will drop one level and complete the level again. Each level has identified privileges, which include a progressively later bed time, kitchen privileges, extra game room time, movie night with a special treat once or twice a month, or scheduled outings, if behavior permits. The program's policy does not specify the four-to-one ratio regarding the recognition of accomplishment and positive behaviors; however, the staff receive motivational interviewing training which ensures this ratio is utilized. The BMS is designed to maintain order and security, provide positive and negative consequences, discuss alternative behaviors, provide opportunities for staff and youth to discuss the impact of their behavior on others, provide opportunities for positive reinforcement, and provide opportunities for youth to explain their behavior. The program's BMS outlines levels of intervention, to include a friendly non-verbal phase, a concern non-verbal phase, a helpful verbal phase, request for staff and/or youth support, staff intervention, and if needed, physical restraint. The program's policy indicates major violations are addressed in a disciplinary hearing process and multiple major violations are addressed in an emergency treatment team. The BMS is clearly posted in the multi-purpose area, or pavilion, and is included in the youth handbook. A review of five youth case management records confirmed the BMS was reviewed with each youth during orientation.

Observations during the annual compliance review included staff addressing behaviors with youth and youth being given an opportunity to explain their behavior. Five interviewed youth were able to explain the difference between each level of the BMS and how to move from level to level. When asked about consequences used, youth reported they may get a write-up, lose their level, have goals added, or possible restriction of outside activities. Each youth reported rewards utilized at the program include outings, special food on Monday or Friday, and fast food or other outside food choices.

An interview with the facility administrator reflected the program utilizes a four-tier behavior modification tool and the program implemented a second phase to the level system known as the token economy, which began in April 2018. The token economy rewards positive behavior and at the end of the week, with youth being allowed to spend their tokens on items at the Duval Store. The facility administrator reported BMS is a simplified system created by the therapists, case managers, transitional specialist, and education department.

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 policy and procedures addressing the behavior management system (BMS), which includes consequences and sanctions. The program does not utilize room restriction. The program's policy does not specifically address a protocol where staff are provided feedback regarding their implementation of the BMS; however, a practice is in place as evidenced by an interview with the facility administrator and staff interviews indicating they are provided feedback through coaching notes, verbal communication, and shift briefings. In addition, a sample of job descriptions reviewed clearly showed each staff's job function included providing rewards and consequences as prescribed in the program's BMS. Two performance evaluations completed for direct care staff were reviewed and each addressed a goal regarding the staff's consistent implementation of the BMS.

Five youth interviewed reported they are never allowed to punish other youth. Youth reported staff are consistent in the use of rewards and treat the youth fairly. When asked how the youth would rate the BMS, each youth reported they would rate it as good. An interview with the facility administrator reflected the BMS is monitored by the transitional specialist and clinical director. The facility administrator stated level promotions are posted when a youth's level changes. The levels are also maintained in a separate BMS binder, which is reviewed and updated after treatment team meetings.

5.04 Ten-Minute Checks (Critical)	Limited 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 policy and procedures stating ten-minute checks will be completed anytime youth are placed in their rooms. The facility maintains video footage of ten-minute checks for a period of thirty days. Video and ten-minute check sheets for five randomly selected days were reviewed. The ten-minute check sheets for each night documented staff checked on youth in their room every nine minutes for the entire night. However, a review of video showed multiple checks, six in all, on different nights were not performed in accordance with the documentation on the ten-minute check sheets. The Central Communications Center (CCC) was contacted to report the falsification of ten-minute bed check sheets and a report was taken. Five staff were interviewed. All five staff reported youth are checked every ten minutes when in their rooms.

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

The program has a policy and procedures to address youth census, counts, and tracking. Logbooks for the past six months were reviewed. The logbooks documented admissions, releases, and when youth were taken off-site. Counts were documented in the logbooks at the beginning of each shift and every hour. The youth headcount is also documented on the shift report log for briefing purposes. Logbooks showed proper counts were taken and cleared after a qualifying emergency and simulated drills. Observations confirmed counts were completed at the beginning of each shift and every hour. Two formal head counts were observed from master control. The master control operator gave a two-minute warning to all staff to prepare for the count. Each count was controlled, accurate, and cleared without issues. Five staff were interviewed. The five staff knew to process to reconcile a count, stating all movement stops until the count clears.

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 maintains a chronological record of events, incidents, and activities in a central logbook maintained at master control. Logbooks for the past six months were reviewed. The logbooks were bound with pages numbered. All entries were made with ink and there were no entries removed through erasure, whiteout, or other methods. Entries were legible and included the date, time, brief description of the event, including names of staff or youth, and the name and signature of the staff making the entry. The logbook documented head counts at the beginning of each shift and every hour after. Documentation of daily perimeter checks, as well as all youth movement can be found in the program-maintained logbook. Recent Central Communications Center (CCC) incidents were logged in the logbook. The logbooks appeared to reflect all program activities. Shift briefings and reviews of previous shifts were noted in the logbooks and shift 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 policy and procedures for key control, which addresses assignment of keys, tracking of keys, missing or lost keys, and reporting of and replacement damaged keys. Training on key control has been provided to staff. Visitors must turn in personal keys before entering the facility and receive a “chip” identifying the hook their keys are placed on. A visual inspection was made of all four key storage locations. The first key control box in the main lobby contains visitor keys and identifying chips. A second key control box contains all primary facility keys for staff on duty. The staff turn in their personal keys and receive their assigned facility keys for their shift, and then turn in the facility keys at the end of the shift. The issuance of facility keys for each staff key is documented. The third key box encompasses two separate combination coded lock boxes containing all medical associated keys for admittance to the medical offices and medication storage. The fourth lock box contains all spare/duplicate keys, restricted keys, emergency keys, and is secured in a lock box in the locked plant manager’s office. All transport van keys are securely housed in the master control room. A review of the key inventory found it accurately reflected the number of keys on each key ring.

Five staff were interviewed. All of the staff knew the process for missing or damaged keys. Each staff knew the procedures for receiving and turning in assigned work keys and personal keys. Staff knew all visitors must turn in their personal keys and receive a chip prior to entry into the facility.

5.08 Contraband Procedure	Limited Compliance

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

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

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

The program has a policy and procedures to address contraband, to include the confiscation of contraband. Reviews of facility logbooks, youth search forms, and contraband logbooks were conducted to verify youth room and dorm searches were conducted. Shift reports included documentation of perimeter checks. All youth are provided a resident handbook at intake, which identifies the disposal of contraband by program staff or law enforcement, if needed. The youth handbook did not address and/or define what is considered contraband. Page 28 of the youth handbook stated “being in possession of contraband, weapon, or firearms, etc.” is considered a major offense. Five youth records reviewed found the youth orientation procedures included a discussion of items considered contraband. The list, however, did not specify the required prohibited list of items, such as personal cell phones, equipment, and/or electronic devices capable of taking pictures and/or audio/video recordings, which are prohibited in the secure area. While on-site, the program updated the youth handbook to clearly define what is considered contraband to clearly identify contraband items and had all youth sign an acknowledgement of receipt of the new handbook. The five records reviewed found the program did not document contraband obtained from youth searches in the youth’s case record. When contraband was discovered, the contraband was documented on the search forms.

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 policy and procedures to address searches and full body visual searches of youth. Observations of staff performing youth searches were conducted on several occasions when there was youth movement throughout the facility. Searches were conducted by male staff (same gender as youth). Staff conducting the searches were respectful of youth during the searches. A review of youth case management records showed documentation of youth full body visual searches were performed upon youth entry into the facility and each time of re-entry, when applicable. Full body visual searches were documented on a body chart and in the log book.

Five staff and five youth interviews were conducted. The staff reported only male staff conduct searches. Both youth and staff reported searches are conducted after activities and youth movement within the facility.

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

The program currently has two vans utilized for transportation of youth. Documentation reflected each vehicle received an annual safety inspection with one inspection completed in November 2018 and the other inspection completed in December 2018. Each vehicle's record documented a preventive maintenance form indicating when an oil and filter change occurred, a rotation and balance of the tires, and inspections of the brakes, hoses, cables, lights, horn, filters, fluids, seat belts, exhaust system, and the parking brake. Invoices for each vehicle were maintained by the program, documenting the service to the vehicles were completed. Each vehicle was equipped with the appropriate number of seatbelts, a knife for life, which is utilized as a seat belt cutter, a window punch, fire extinguisher, and a backpack first aid kit, which is maintained in master control for each vehicle. Upon inspection, each vehicle was locked. Youth are not attached to any part of the vehicle by any means other than proper use of a seat belt. A transport was not able to be observed during the annual compliance review. One vehicle was identified as having a broken side door/latch on April 19, 2019, which is scheduled to be repaired on April 30, 2019. The daily vehicle usage log confirmed the vehicle has not been utilized since April 19, 2019, when the issue was identified.

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

The program has a policy and procedures addressing transportation of youth, which includes the use of mechanical restraints for youth being transported. Driver license checks are conducted annually by the facility administrator to ensure all staff have valid Florida driver's license. Transport vehicles are searched prior to transport and upon return to ensure no contraband is present. Staff take cell phones on transports to allow for communication with the facility. Staff do not transport youth in their personal vehicle and never allow youth to drive facility or personal vehicles. Observations of facility transport vehicles showed the two vans and one truck were locked when not being utilized. One facility transport van had a broken side door lock, which had already been identified prior to the review. The van was already scheduled for repair prior to the annual compliance review and was not utilized for youth transport pending the repair. Random staff vehicle checks showed them to be locked and inaccessible. Five staff were interviewed and were able to explain the program's transportation procedures.

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

The program has a policy and procedures addressing weekly safety and security audits. The policy indicates the facility administrator and/or designee is responsible for ensuring all aspects of the facility are safe and secure for youth, staff, and visitors. The policy outlines any deficiencies identified are reviewed by the facility administrator and a corrective action is developed and documented on the safety and security audit tool. Once the deficiency is corrected, the facility administrator will approve the deficiency to be removed from the safety and security audit document. An interview with the facility administrator confirmed the program has an internal process regarding the identification and tracking of deficiencies to ensure they are addressed by the program as outlined with their policy and procedures.

Documentation showed the program conducted a facility security audit and safety inspection on a weekly basis. Each inspection noted any concerns, comments, corrective action needed, and date the corrective date is to be completed. Several of the inspection reports documented the completion date of previously identified concerns, and when the deficiencies were corrected. Each security and safety inspection was completed by the facility administrator or the assistant facility administrator and the maintenance supervisor.

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.	

Inventories of the kitchen, operations, and the maintenance tools were conducted. While reviewing the tool room, a random check from the official inventory list was conducted. No tools were found to be missing or damaged. All tools observed were clearly identified with a tool number. The shadow board clearly outlined all tools with an identification number for the tool placed there. All tools in the tool room were properly signed out and back in by staff when used. While reviewing the kitchen tools, no cooking tools or knives were noted as missing. One knife was noted as damaged because it would no longer hang on the shadow board, but it could still be safely utilized. Each tool/knife was properly labeled with a tool number and all were accounted for. All tools were properly stored in a locked cabinet behind a locked door. During the review of the program's tools, all tools were found to be secure and non-accessible to youth. Staff are trained on the safe use of tools.

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

The program has a policy and procedures to address youth use of tools. Staff supervise youth at all times when youth use mops and/or brooms during cleaning activities. Youth are only permitted to use the aforementioned tools. Risk assessments and reassessments are completed for each youth by the case managers and maintained in youth records. The risk assessment and reassessment include if youth are eligible to use tools. Five staff and five youth were interviewed. All staff and youth indicated the only tools youth may use are mops and brooms.

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

The program has a policy and procedures outlining protocols for outside contractors who perform work at the facility. Documentation showed an inventory log is completed when outside contractors bring tools into the facility. The inventory log is checked upon entry and exit to ensure the program and contractor can account for all tools utilized by outside contractors. A review of the recent contractor logbook entries for the facility matched submitted invoices for contractor services.

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 Continuity of Operation Plan (COOP), which states unannounced fire drills will be conducted at least monthly under varied conditions and across all shifts. The drills are to be documented in a fire safety log. A review of the fire safety logs showed fire safety drills were conducted at least once a month. The logs also showed the program conducts varying scenario safety drills including power outages, chemical spills, and work place violence drills. Due to recent youth escapes, the logs also showed the program performed monthly mock escape drills to critique and strengthen their internal processes for youth escapes.

Five youth were interviewed. All youth reported they have been informed of what to do in the event of a fire and they have participated in fire drills. Five staff were interviewed. All staff reported participating in multiple types of emergency drills, to include fire, evacuation, escape, weather, bomb threats, and major disturbances.

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

The program has a single comprehensive plan, which incorporates both the Continuity of Operation Plan (COOP) and the Emergency Disaster Preparedness Plan. The plan was submitted to and approved by the Department's residential regional director. The plan details and contains alternative housing plans, delegations of authority, vendor lists, staff contact numbers, and emergency numbers. Interviews were conducted with the facility administrator and assistant facility administrator to determine the COOP plans location. The COOP is stored in the master control room, facility administrator's office, and the assistant facility administrator's office, with all three being accessible to staff for review. A review of ten training record showed staff have been trained on emergency procedures.

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 procedure addressing the storage and inventory of flammable, poisonous, and toxic items and materials. The policy and procedures address issuance and accessibility, as well as identifies certain hazardous chemicals to only be handled by specifically identified personnel with proper training. All active, general cleaning chemicals for the kitchen and youth dorms were stored in a separate secure closet with complete and accurate inventory sign-out sheets. All surplus cleaning chemicals for the kitchen and youth dorms were securely stored in a storage closet outside, which is inaccessible to youth. All surplus chemicals were accurately inventoried with proper documentation indicating when surplus was taken. Safety Data Sheets (SDS) were maintained for each chemical along with an individualized chemical inventory sheet. A review was conducted of the secured outside storage closet, which contained all flammable chemicals, paints, oils, and miscellaneous chemicals, which were stored in a fireproof safety locker. The storage closet inventory sheet reflected an accurate account for all items in the inventory. All chemicals were found to be accurately accounted for with proper sign in/out sheets for utilization.

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.*	

Program policy and procedures prohibit youth from handling flammable, poisonous, and toxic items. Procedures are in place for supervision of youth who assist in cleaning activities, requiring staff to maintain control of any cleaning agents used. Annual compliance review team observations and documentation reviewed found youth did not handle any toxic items. Biohazard spill kits are stored in both dorm sub controls. Five youth were interviewed and reported they do not have access to paint, bug spray, gas, rubbing alcohol, paint stripper, floor wax, bleach, laundry soap, or window/toilet cleaner.

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

The program has a policy and procedures for the disposal of flammable, poisonous, and toxic items. The program has had no incidents of chemical spills for the annual compliance review period. Mop water and excess kitchen fluids are disposed in plumbing drains. The program utilizes a grease pit/trap to store all used cooking grease/oil until time for proper disposal. An interview with the plant manager found chemical disposal practices were in accordance with disposal instructions listed on Safety Data Sheets (SDS). The facility administrator interview

showed he was familiar with the program's process and practices for the disposal of flammable, toxic, caustic, and poisonous items.

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

The program has a policy and procedures for recreation and leisure activities, which was reviewed by the facility administrator at the time of the annual compliance review. The program has a recreational therapist, who has the proper credentials. A review of the weekly activity schedule showed youth are provided at least one recreational or leisure activity once a day for a minimum of one hour. A sample of the recreation and leisure activities include strength training, flag football, basketball, gravity assisted strength training, balance training, fundamentals of stretching before activity, board games, and video games. Daily recreation and leisure activities were observed and found activities took place as scheduled.

Five staff and five youth were interviewed. All youth and staff reported youth receive at least one hour of physical activity daily. Staff interviews confirmed the various recreation and leisure activities provided. A review of five youth records found recreational goals were included on each of the performance plans.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures to address the responsibility of the program to provide youth with visitation and communicative access to previously approved family members and individuals as well as access to state, judicial, and legal representatives. The policy identifies the day and times in which visitation is permitted and the procedure for family members to follow to become eligible for visitation. Copies of the visitation policy are provided to the parent/guardian and youth during the orientation process. There are separate policies for written and telephonic communication. Both policies specify the access youth have to written and telephonic communication and in what circumstances, if any, the communication is monitored. According to the policy, youth are encouraged to maintain open lines of communication with their family. Youth phone logs were reviewed, showing weekly phone calls to parents/guardians or approved individuals. There were also logs documenting incoming or outgoing mail for youth. Youth visitation is documented on the main visitor sign-in sheet

maintained in the program lobby. The logs showed youth had contact with only approved family members or individuals. Five youth were interviewed. All youth reported they are given the opportunity to communicate with family members by mail, telephone, and visitation.

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

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

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

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

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

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

Program Name: Duval Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Duval County / Circuit 4
Review Date(s): April 23-26, 2019

MQI Program Code: 1280
Contract Number: 10094
Number of Beds: 28
Lead Reviewer Code: 37

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.14 Internal Alerts System and Alerts (JJIS)*	3.12 Suicide Precaution Observation Logs*
5.04 Ten-Minute Checks*	
5.08 Contraband Procedure	