STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Escambia Boys Base

AMIKids, Inc.
(Contract Provider)
Building 3780 Corry Station
Pensacola, Florida 32511

Review Date(s): February 18-21, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Patrick M McKinstry, Office of Program Accountability, Lead Reviewer (Standard 1)
Jennifer Bailey, Office of Program Accountability, Program Accountability Bureau Chief, (Standard 2)
Lauren Floyd, Office of Program Accountability, Operation Review Specialist (Standard 2 & Interviews)
Melissa Johnson, Office of Program Accountability, Central Region Supervisor (Standard 4)
Patrick Morse, Office of Program Accountability, South Region Supervisor (Standard 5)
Maryann Sanders, Office of Program Accountability, South Region Deputy Supervisor (Standard 3)
Stephanie Shay, Office of Program Accountability, Central Region Deputy Supervisor (Standard 4 and Interviews)

Program Name: Escambia Boys Base
Provider Name: AMIKids, Inc.
Location: Escambia County / Circuit 1
Review Date(s): February 18-21, 2020

MQI Program Code: 1271
Contract Number: 10079
Number of Beds: 28
Lead Reviewer Code: 144

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

Overall Rating Summary

Overall Rating Summary
This program has received an overall program compliance rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.

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

Limited Ratings	Failed Ratings
1.14 Internal Alerts System and Alerts (JJIS)*	1.02 Five-Year Rescreening
1.17 Advisory Board	1.18 Program Planning
2.07 Residential Assessment for Youth (RAY)	2.11 Performance Summaries and Transmittals
4.13 Off-Site Care/Referrals	2.13 Members of Treatment Team
5.03 Behavior Management System Infractions and System Monitoring	2.15 Treatment Team Meetings (Formal and Informal Reviews)
5.04 Ten Minute Checks *	2.19 Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)
5.05 Census, Counts, and Tracking	3.13 Suicide Prevention Training *
5.08 Contraband Procedure	3.15 Crisis Assessments *
5.16 Fire, Safety, and Evacuation Drills	3.17 Baker and Marchman Acts *
	4.01 Designated Health Authority/Designee *
	4.02 Facility Operating Procedures
	4.04 Parental Notification/Consent
	4.12 Episodic/First Aid Care/Emergency Care
	4.15 Medication Management
	4.17 Infection Control/Exposure Control
	5.06 Logbook Entries and Shift Report Review
	5.07 Key Control*
	5.26 Safety Planning Process for Youth

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Satisfactory
1.02	Five-Year Rescreening	Failed
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	Non-Applicable
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	Limited
1.18	Program Planning	Failed
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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

Overall Rating Summary for Standard 4

This standard has received a standard-level rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.

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	Limited
5.04	Ten Minute Checks *	Limited
5.05	Census, Counts, and Tracking	Limited
5.06	Logbook Entries and Shift Report Review	Failed
5.07	Key Control*	Failed
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	Limited
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Satisfactory
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable
5.26	Safety Planning Process for Youth	Failed

* 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).

Overall Rating Summary for Standard 5

This standard has received a standard-level rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.

Program Overview

The Escambia Boys Base is a twenty-eight-bed program, for fourteen to eighteen year old males, located in Pensacola, Florida. The program is operated by Associate Marine Institute (AMI), Incorporated. through a contract with the Department. The program provides mental health overlay services (MHOS). In addition, the program fosters each youth by providing aggression replacement therapy (ART), Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT-12), The Council for Boys and Young Men, and the Impact of Crime (IOC) curriculum. Additional treatment services provided includes family and individual therapy, religious and spiritual opportunities, community involvement, and job training placement. The program administration is comprised of an executive director, director of operations, director of treatment, compliance specialist, and business manager. Case management services are provided by two case managers. Mental health staff at the program includes one director of treatment, four non-licensed therapists, and a contracted psychiatrist. Medical health staff at the program include two full-time registered nurses (RN), three part-time RNs, and one contracted designated health authority. Educational services are provided by the Escambia County School Board. At the time of the annual compliance review, the program had three vacant positions; one case manager and two direct-care staff. The layout of the program includes one building, which encompasses administration, medical, mental health, case management, youth housing, and education. Dining for the youth is provided on base at a separate location at the Corry Station Naval Training Center. The program has fifteen operating security cameras providing coverage.

Standard 1: Management Accountability

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

Eighteen employee personnel records were reviewed for initial background screening requirements. All eighteen staff had evidence of a background screening completed prior to the initial hire date. The background screenings included a review of the criminal history report information. None of the staff had a break in services. None of the background screenings determined the staff were ineligible for hire. The provider added the employees to the Clearinghouse employment roster for all reviewed records. Ten of the eighteen reviewed records were applicable for requiring a pre-employee assessment tool. Staff for the ten records had a pre-employment assessment and passing score documented within the personnel record. The program reported having had no volunteers or contracted staff who would require an initial background screening for this annual compliance review period. The program submitted an Annual Affidavit of Compliance with Level Two Screening Standards to the Background Screening Unit (BSU) on January 28, 2020. Teachers employed at the program are paid through an agreement with the local school board and Department of Education. Annual screenings are completed through an Annual Affidavit of Compliance with Level Two Screening Standards to the BSU by the Escambia County School Board on January 6, 2020. The program has a written policy and procedures indicating documentation practices to confirm the program's hiring authority reviewed the Central Communications Center (CCC) person involvement history, Staff Verification System (SVS) module, and Florida Department of Law Enforcement (FDLE) results. The program's human resources manager is primarily responsible for confirming the process for completion of the background screening ancillary review of documentation.

1.02 Five-Year Rescreening	Failed 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's written policy and procedures address practices for completion of five-year background rescreening which are to be calculated from the hire date. A review of the program's employee roster revealed there were two staff who required a five-year background rescreening. Both reviewed five-year background rescreening's was not submitted to the Department's Background Screening Unit (BSU)/Clearinghouse prior to the staff member's five-

year anniversary date. One staff rescreening was submitted nineteen days after the five-year anniversary date and the other staff member's rescreening was submitted approximately eight months after the respective five-year anniversary date. The program reported they did not have any volunteers, mentors, and/or interns who required a five-year rescreening since the last annual compliance review.

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

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

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

The program had a total of eleven Central Communications Center (CCC) calls since the last annual compliance review. One of the eleven incidents was allegedly related to physical, psychological, or emotional abuse. The one applicable CCC incident reviewed had recently occurred at the program in January 2020. No findings have been reported or found related to physical, psychological, or emotional abuse. Five staff personnel records were reviewed for adherence to the provider's code of conduct. Each of the reviewed staff personnel records contained a signed copy of the code of conduct. During the tour of the program, each of the staff present during the annual compliance review indicated having observed postings of numbers for the CCC and the Florida Abuse Hotline.

The program's written policy and procedures addresses incident reporting requirements and child abuse reporting practices. Abuse telephone numbers are posted throughout the program making it readily available to staff and youth. An immediate oral report is required by the person having first-hand knowledge of the incident (suspected child abuse). The report is made to the Florida Abuse Hotline . The report should answer "who, what, when, where, why, and how". If a youth wants to make a call to the Florida Abuse Hotline, the supervisor on duty will escort the youth to a telephone. The supervisor will assist the youth in placing the call to the appropriate agency. The supervisor will speak to the contact person on the other end to ensure the proper identifying information is provided such as program telephone number, location, and directions. Once the call is made, the supervisor will contact the parent/guardian and the executive

director. Notation of the alleged occurrence will also be documented in the logbook. The assistant executive director, or designee, will initiate and document applicable corrective action. The program completed a TRACE self-assessment on July 3, 2019. The program has no substantiated incidents related to physical, psychological, and/or emotional abuse since the last annual compliance review.

Interviews were conducted with five youth. All five youth stated they felt safe at the program. None of the five youth reported ever having been stopped from reporting abuse to the Florida Abuse Hotline or CCC, if eighteen years of age or older, since they have been in the program. Four of the five youth stated staff are respectful while talking with them and other youth. One youth replied, not all stating a particular staff does not allow the youth to go to the gym even if they are on the corrective action plan chart. The youth stated the staff does not speak to kids respectfully. The youth was questioned if they heard staff use profanity when speaking with them or other youth and how often. Two youth replied, never, two stated occasionally, and one replied, often. Two youth further explained, the staff does not use profanity towards the youth. One youth reported a particular staff use profanity at youth every day. The allegations as reported by the youth within the interviews were discussed with program administration. Interviews were conducted with five staff. The staff were able to articulate the practices for allowing staff and youth to call the Florida Abuse Hotline or CCC for suspected abuse. The interviewed staff stated they have never observed a co-worker tell a youth they could not contact the Florida Abuse Hotline. Four of the five staff stated they have never observed a co-worker use profanity when speaking to youth, use threats, intimidation, or humiliation when interacting with youth. The one staff stated some staff use profanity in general statements.

An interview with the program director indicated all AMIkids, Inc. staff shall model pro-social behaviors for youth throughout the course of each day in the program, reinforce delinquency interventions, and guide and redirect youth toward pro-social behaviors and positive choices. Staff behavior should be respectful of others and reflect desired behaviors for youth. Staff shall not use corporal punishment, profanity, threats, or intimidation in the presence of youth. New employees shall be oriented to the requirements of an abuse-free environment as a component of the orientation process. These requirements are listed in the employee handbook. It is the director of operations or designee's responsibility to ensure the posting of the Florida Abuse Hotline and the CCC for youth eighteen years of age and older, telephone numbers in each building. The director of operations, or designee, will ensure 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. Unhindered is defined as facilitating the youth's request to call the Florida Abuse Hotline as soon as reasonably possible with no screening by any program staff. Staff have the ability and responsibility to call the Florida Abuse Hotline immediately. The environment is free of physical, psychological, and emotional abuse. Program staff will comply with policies for alerting the Department's CCC within two hours of the occurrence or knowledge of reportable incidents.

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

The program had a total of eleven Central Communications Center (CCC) calls since the last annual compliance review. One of the eleven incidents was allegedly related to physical, psychological, or emotional abuse. The one applicable CCC incident reviewed had recently occurred at the program in January 2020. No findings have been reported or found related to physical, psychological, or emotional abuse. The provider's internal investigation for the one alleged incident supported management took immediate action to address the alleged incident of physical, psychological, and emotional abuse. An interview with the program director revealed the following procedures will be implemented when allegations of abuse or neglect are made by youth or staff: The program administration must be immediately made aware of the allegation which may include the executive director, compliance specialist, or director of operations. Depending on the nature of the allegation, a call will be made to the Florida Abuse Hotline followed by a call to the CCC, if applicable. The program administration will conduct an internal investigation to determine the implementation of any immediate action. Administration will review any incident report, interview staff and youth, and implement corrective action to ensure the safety of youth. The executive director or designee will initiate and document applicable corrective action. The corrective action plan can be in different forms including but not limited to a memo, general staff meeting, or individualized counseling. The corrective action plan is not contingent on confirmed allegations. All program staff will cooperate with all aspects of any investigation conducted by the program administration or officials from the Department's Office of the Inspector General.

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

The provider had a total of eleven Central Communications Center (CCC) calls since last annual compliance review. A minimum sample of five CCC reports were reviewed. In three of the five reports reviewed, the CCC was notified within two hours of the program becoming aware of the incident. The remaining two CCC calls were not applicable for a report time due to the type of incident. Two of the CCC calls were applicable for a report time and found documented in the program's logbook. There were no indications of any internal incident reports and/or grievances which should have been reported to the CCC. During the annual compliance review, there were several instances of missed medications and one incident of falsification. The alleged incidents when discovered, were reported to the CCC. According to residential operations, the program has had a decrease in the total number of reportable incidents to the CCC since the last annual compliance review.

The program director explained the program's incident reporting process by stating program staff will comply with policies for alerting the Department's CCC within two hours of the occurrence or knowledge of reportable incidents. The CCC reports are maintained in the director of operation's CCC reports binder. Program staff shall provide an update of any pertinent information missing from the initial incident report by 10:00 a.m. the day after the

incident was reported to the CCC. The update will be made electronically or by calling the CCC. Program staff will notify the parent/guardian of any youth who escapes or attempts to escape, has a serious illness, or needs medical treatment requiring a visit to the doctor/hospital or requires emergency first aid at the program, and if a youth communicates a desire to commit suicide or is in danger physically. When notifying the parent/guardian, the director of operations, or designee, will call the parent/guardian and record the conversation in the youth's case record. Unsuccessful attempts will be recorded in the same place. In the event the parent/guardian cannot be contacted by telephone, a written notification will be sent. Should an incident be deemed not reportable to the CCC, an internal incident report must be completed by the staff member before their shift is over and must be submitted to the director of operations or designee. The shift supervisor and/or the director of operations shall be notified of the incident prior to the end of the shift. The incident will be noted in the shift log and all pertinent parties will be notified. Once the shift supervisor or director of operations is made aware of the incident report, they will investigate the incident within twenty-four hours and ensure no additional action is required. In the event the shift supervisor or the director of operations is not available or cannot be reached, the executive director must be notified.

1.06 Protective Action Response (PAR) and Physical Intervention Rate	**Non-Applicable**
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 reported they have not utilized any physical interventions or mechanical restraints during the annual compliance review period. The program's Protective Action Response (PAR) rate during the annual compliance review period was 0.00, which is below the statewide Residential PAR rate of 2.41.

The program director explained the process for monitoring PAR incidents and use of force. All staff and managers will read, receive instruction on, and issued a copy of the Associated Marine Institutes (AMI) physical restraint policy upon accepting employment at a program. Signed copies of the document is placed in the staff's personnel folder. Youth will sign a restraint policy upon admission to the program and have explained to them the behavior which would result in a physical intervention. When a youth requires physical intervention, the staff member and shift supervisor is responsible for completing a Department PAR report documenting the circumstances, justifications, and results before leaving the facility. In the event a physical restraint results in the injury of a staff or youth, the injury must be documented on the program's incident report, accompanied with a completed PAR report to the AMIkids, Inc. headquarters. Program management will submit the report to the AMI regional director and any contracting parties as outlined in the contract. The medical staff on-site must examine the youth to determine if treatment is required or consulted to determine if the youth requires immediate outside medical treatment. Youth requiring outside medical treatment should be reported to the Department's Central Communications Center within two hours. Only the degree of force necessary will be utilized to restrain youth. Mechanical restraints cannot be used to restrain youth except for transport reasons. Pain management techniques may not be used to restrain youth. Program staff will not, at any time, employ the use of mechanical restraints for the purposes of behavior control or punishment. One of the program's major objectives is to help youth change their lives by having them build a foundation of success while in the program..

Supervision at AMIkids, Inc. enables a staff to intercept potential problems and to convert these situations into positive learning experiences. Verbal intervention will always be the first method utilized by any program staff when addressing a youth's behavior. AMIkids, Inc. subscribes to the counseling philosophy of Motivational Interviewing, a technique which stresses personal responsibility and accountability. All program staff will be made familiar with this philosophy as part of the core pre-service training. Staff and administrators will observe youth for signs of potential behavior issues. Youth who appear to be upset, even if they are not verbally or physically misbehaving are removed from the group and given individual counseling to help determine and resolve the issue. Staff will call a shift supervisor on the radio if a staff member needs to address a behavior issue privately with the student. The shift supervisor is to ensure proper supervision is maintained while the staff member offers verbal counseling to youth. To avoid having to perform a physical intervention and to ensure this is a method of last resort, a youth who becomes visibly upset is to immediately request to step out of the environment which is upsetting the youth with a staff to process and deescalate. Program staff will utilize this technique as a preventative measure to be proactive in preventing physical interventions. Any time a physical intervention is utilized, the director of operations is to be immediately notified. The director of operations, or designee, will remain on twenty-four hour call for this purpose. When a restraint is used, a team approach will be used whenever possible. All applicable reports will be completed and submitted to the appropriate parties.

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

Five staff training records were reviewed for pre-service training requirements. Each record revealed each staff had over the 120 minimum hours required of pre-service training. Each staff received training for cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professional ethics and standards of conduct, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA). A review of the provider's contractual agreement included additional required trainings outlined for pre-service requirements. Each of the five records reviewed found the staff all received the additional trainings to include the restorative justice, transition planning, gender responsive, trauma/post traumatic stress disorder (PTSD), and universal precautions. All training was documented within the Department's Learning Management System (SkillPro). All instructors were qualified to deliver training provided. The program submitted, in writing, a list of pre-service training to the Department's Office of Staff Development and Training on January 1, 2019 which included course names, descriptions, objectives, and training hours for any required instructor-led training.

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

A sample of five staff which included two supervisory staff, were selected to review in-service training completed for the 2019 calendar year. All five reviewed records contained over the

twenty-four hours of the required annual training. Each record contained evidence the staff received in-service training for cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR) eight-hour refresher training, professional ethics and standards of conduct, and suicide prevention which included four hours of instructor-led training and two hours of training completed within the Department's Learning Management System (SkillPro). A review of the provider's contractual agreement found there were no additional in-service trainings required for the sample selected. The two supervisory staff selected received the additional eight hours of required supervisor training in areas related to management, leadership, personal accountability, employee relations, communication skills, and fiscal training. All in-service training reviewed was documented within SkillPro, as required. All instructors were qualified to deliver training provided. The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training on January 1, 2019 which included course names, descriptions, objectives, and training hours for any required instructor-led training. The program had an annual in-service training calendar, which is updated as changes occur. An interview with the program administration revealed only staff who received training in PAR may supervise youth which includes direct-care staff, maintenance staff, team leaders, and operations managers.

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's written policy and procedures include the training requirements of the grievance process. A sample review of staff training records determined staff received the required training on the program's grievance process and procedures. The program's grievance process includes the informal, formal, and appeal phase. The informal phase includes a resolution with the youth at time of the complaint with on-duty staff at the time of the occurrence. During the formal phase, the youth submits a written grievance to the supervisor in which a decision is rendered within seventy-two hours. The appeal phase includes the executive director or designee shall review the grievance and make a decision within six days. The program maintains copies of the grievances for the past twelve months. The program had one grievance for the past twelve months which was reviewed. The grievance contained the nature of the grievance and documented the informal phase complaint. The grievance was resolved at the formal phase within the specified time frame. The program utilize a "411" form, which affords youth the opportunity to openly discuss items of concerns. The "411" process is not to be used to supersede a youth's ability to file a grievance.

Five interviewed youth explained the program's grievance process. Each of the five interviewed youth reported they can request assistance when completing a grievance form. Five staff were interviewed and explained the program's youth grievance process. All five staff provided information pertaining to practices necessary for assisting youth in the grievance process.

The program director was interviewed and explained the program's grievance process. The program youth are allowed to grieve, in writing, the actions of program staff or peers and conditions or circumstances of care and treatment which are in violation of their rights. Youth are afforded the right to grieve and treated fairly, respectfully, and without discrimination. Program staff will protect the rights of all youth. Youth are able to access grievance forms

without impediment by retrieving grievance forms located near the grievance lock boxes in their living areas and education building. Youth can request grievance forms from any staff. Youth can place their completed grievance forms in any of the grievance lock boxes located throughout the program or give to staff. Staff will be trained on the grievance process and procedures. The staff conducting orientation for youth will provide a verbal explanation of the grievance procedures. A written copy of the grievance procedures will be provided to the youth at orientation and to the parent/guardian, if present. If not present, the staff mails a copy to the parent/guardian. Staff shall ensure a youth requesting to file a grievance be given the necessary forms and any assistance needed to complete the forms and file the grievance. Every grievance submitted by youth will be taken seriously. Program staff are committed to ensuring all youth feel the grievance system is a reliable method to resolve their issues. All grievances and outcomes are maintained on file for at least one year.

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

The program has five staff who are regularly assigned duties to include the implementation of an intervention and/or curriculum. Each of the five staff reviewed were trained in a specific delinquency intervention model. All training reviewed for each staff noted the staff's date of training. In addition, the staff personnel records noted their education level. The staff reviewed had a number of years of experience working with adult and/or youth offenders. The program management considers the education and work experience of staff when determining delivery of delinquency intervention services. A review of the provider's contractual agreement included the required delinquency intervention services are Aggression Replacement Training (ART), The Council for Boys and Youth Men, Impact of Crime (IOC), and Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT-12). The Council for Boys and Youth Men, ART, and MET/CBT-12 are an evidenced-based intervention. The IOC curriculum is a promising practice. The program's written description addresses delinquency intervention strategies. A review of the program's activity schedule determined the program provides structured and planned programming or activities for at least sixty percent of the youths' awake hours. A review of group sign-in sheets for each of the program's contracted delinquency interventions demonstrated groups are delivered as indicated on the program's youth activity/group schedule. A sample review of five staff training records was conducted, each of the five staff were trained on the program's evidenced based strategies.

Five youth records were reviewed for involvement in a delinquency intervention which is evidence-based, promising practice, a practice with demonstrated effectiveness, and any other intervention approved by the Department. Each of the reviewed youth participates in at a minimum one of the program's delinquency interventions. The reviewed youth were involved in a delinquency intervention addressing an identified priority need. The youth's performance plan addressed an identified priority need. The program director explained how staff education and work experience were considered when determining which staff will deliver life skills trainings/groups. All staff facilitating groups are master-level clinicians or bachelor's-level professionals who all had previous work experience with youth, which was all verified prior to hiring. Youth are matched to staff/counselors upon intake and caseload availability. Youth are placed in intervention groups dependent on their diagnosis and treatment need, which is

accessed within the first thirty days of intake. The delinquency intervention model or strategy utilized at the program, according to the program director, is Cannabis Youth Treatment, ART, IOC, and Council for Boys and Young Men.

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

A review of the program's contract of required services for interventions or instruction focusing on developing life and social skill competencies in youth are Aggression Replacement Training (ART), The Council for Boys and Youth Men, and Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT-12). The youth receive life and social skill intervention services, which specifically address, at a minimum: communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking (to include problem-solving and decision making) skills. The program's process to determine how services are provided is the youth needs are assessed at intake during their comprehensive evaluation by a therapist. Based on this assessment, life skills and social skills curriculum will be provided to youth based upon their individualized need and according to their treatment plan. A review of the program's activity schedule demonstrates the youth are in receipt of life skills education, training, and/or groups, as required. Upon review of group sign-in sheets, it was determined the program's life and social skills are delivered according to the program's group/activity schedule.

The clinical director was interviewed and described their role in the coordination of services at the program overseeing all mental health/substance abuse services, meet with the clinical case managers, therapists, recreation therapist, and the transition coordinator throughout the week for supervision, and hold a formal weekly meeting. The clinical director is available by phone twenty-four hours a day, seven days a week to assist as needed. When a youth is admitted to the program, the youth is staffed by the treatment team and services are tentatively identified. During weekly and/or individual supervision, the treatment team determines what services are further needed for the youth to ensure they are placed in the appropriate groups. In addition, a review of all mental health/substance abuse documentation on a consistent basis. Five youth were interviewed about group participation and what the type of activities they complete in their groups. Each youth identified the groups they were in and what they learned while participating in groups. Each of the youth described the new skills or behaviors they had been taught while in groups.

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 provider's contractual agreement requires the Impact of Crime curriculum (IOC) as the required therapeutic service to be implemented for youth for enhancing restorative justice awareness. These activities facilitated within the curriculum assist youth to accept responsibility for harm caused by their past behaviors which teaches youth about the impact their crimes have on victims, families, and their communities and provides youth various opportunities to plan and participate in reparation activities intended to restore the harms created through avenues such as restitution and community service projects. A review of five staff training records was

completed and revealed all five staff received training for restorative justice awareness as part of their pre-service training requirement. A review of the program's activity schedule, group sign-in and sign-out sheets, and curriculum materials revealed the IOC groups were conducted as scheduled. A sample of five youth records was reviewed and found each youth receives the IOC groups, as required. The program director stated the AMIkids, Inc. supports the IOC group curriculum, which is provided to the youth. All youth are enrolled in the IOC course as well as attend groups in which group speakers with varying background deliver past victim experiences.

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

Based on the provider's contractual agreement, the program provides the following curriculums to address gender responsive services such as The Council for Boys and Young Men, Living a Legacy, and A Right of Passage. The curriculums are designed to address the targeted needs of the program's all male population. A review of the program's activity schedule determined groups are conducted Thursdays from 12:00 p.m. until 1:00 p.m. A review of worksheets, handouts, and youth signature sheets confirmed the groups are conducted, as required. According to the program director, the program addresses the needs of the specific youth population as youth are provided The Council for Boys and Young Men, which is a strength based group approach to promote healthy, masculinity, and development for boys and young men ages nine to eighteen.

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's alerts were inconsistent with the alerts entered into the Department's Juvenile Justice Information System (JJIS). One youth during their time at the program had been noted as having been on medication; however, a JJIS alert was never entered. Two other youth were identified as having allergies; however, an alert was not entered into JJIS. A fourth youth had a medical condition identified at intake and reassessed thirty days later with the same medical condition identified; however, an alert was never entered into JJIS. In addition, when applicable, there was limited documentation contained within the program's logbook and/or shift report supporting alerts were identified and/or communicated to staff. The program's logbook identifies one youth on a medical alert; however, the youth remains on a mental health alert. There was no specific alert or instruction to the specific alert. The program have some alerts noted within JJIS, which were verified prior to entering into JJIS and matched the program's internal alert

system. The program has a written policy and procedures to determine how alerts are identified, documented, updated, and communicated to staff.

Five staff were interviewed on how each are informed of youth alerts including mental health, medical, and security. Staff responses provided a view of those practices into how the program communicate youth alerts to staff. The program director was interviewed addressing the practices for communicating alerts. The program shall maintain and use an internal alert system, accessible to program staff and inform staff on youth who are security or safety risks, youth with health-related concerns including food allergies and special diets. The program's mental health staff can open and close alerts in JJIS. The internal alerts are updated daily by the medical staff and as needed.

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

The program separates the youth records for healthcare, mental health, and case management. The youth records included a file tab of the youth's name, Department of Juvenile Justice identification number, date of birth, county of residence, and committing offense. The youth records contained legal information, demographic and chronological information, correspondence, case management and treatment team activities, and a miscellaneous section. All youth records were labeled as "confidential". All official youth case records are secured in a locked file cabinet or a locked room, as observed while on-site during the annual compliance review. The program clearly identifies any file cabinet used to store official youth case records as "confidential".

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

The program's written policy and procedures addresses a formal process to promote constructive input by youth. This program's efforts to solicit input from youth is conducted through "house meetings". These formalized meetings allow each youth the opportunity to have an input into daily programmatic activities and concerns/issues . The program solicits input from youth through the "411" system. This is another avenue for the youth to provide input on concerns/topics which they feel the need to be addressed. A review of "house meetings" and "411" forms submitted from youth were reviewed. Five youth were interviewed concerning the process allowing youth to provide input on what happens at the program. All five interviewed youth included within their responses they had input through "house meetings". The program director (PD) explained the formal process to solicit input from youth on systemic issues impacting the residential community. The PD stated the program has a formal process to promote constructive input by youth. This process is developed through the utilization of student advisory council, student interviews, suggestion box, and exit surveys. The PD also provided how youth are able to make recommendations for resolutions to improve conditions and enhance quality of life which is accomplished through "house meetings" and "411" forms.

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

The program has an active community support group or community advisory board which meets at least every ninety to 120 days. A review of sign-in sheets, agendas, and minutes from the advisory board meetings was conducted and revealed the program meets, at a minimum, every ninety days. The board consist of community members from the judiciary, business, and other community partners. The program was unable to provide any supporting documentation of where the program director (PD) solicited involvement from law enforcement, school board, faith, and lesbian, gay, bisexual, transgender, and intersex (LGBTI) community. In addition, there was no documentation to support the PD recruited a victim, victim advocate, or any other victim services community representative. There was no parent/guardian whose child was previously involved in the juvenile justice system recruited to the advisory board.

The PD was interviewed and stated the program has a community support group or advisory board meeting at least every ninety to 120 days. The PD solicits active involvement of interested community partners. The PD further stated, the program solicits active involvement of interested community partners including representatives from law enforcement, the judiciary community, the school board or district, the business community, the faith community, and if possible, a representative from the LGBTQI community. The PD recruits a victim, victim advocate, or other victim services community representative, and a parent/guardian whose child was previously involved in the juvenile justice system.

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

A sample of youth and parent/guardian surveys were reviewed for program planning. Each of the surveys solicited input from youth and parent/guardian related to the program. The program did not have any documented management or staff meeting conducted in the past six months. There was no evidence as to whether or not survey results from any source had been incorporated into the program planning process. Lack of documentation demonstrated the program did not have a system of communication to keep staff informed and provide opportunities to provide input or feedback pertaining to operation of the program. The program provides incentives for staff by listing any accomplishments and/or recognition in the Associated Marine Institutes (AMI) newsletter. In addition, the program has a staff appreciation week, annual merit pay raises, anniversary awards, tuition assistance, and employee benefits. The program director (PD) position was filled on January 26, 2020. Recently, the PD communicated regarding the new role and reviewing turnover. Areas to be reviewed and objectives outlined included what signs lead to turnover, actions taken to change outcomes, identify and recommend strategies, and action plan to address turnover. The program's written policies and procedures addresses administration gathering input from a variety of sources to ensure staff are informed of programmatic issues. In addition, the program will include information obtained from both youth and parent/guardian surveys as well as reports published by the Department. The program did not have any formalized staff meetings which were documented in order to provide staff with updated programmatic planning. No frequency and/or attendance could be determined. In addition, due to the lack of documentation, it could not be determined what type of meetings were conducted.

Five staff were interviewed on how often staff meetings are held. One staff replied weekly and the remaining four stated bi-weekly. Topics discussed during meetings includes safety procedures, ratio, procedures, drills, behavior issues, what is going on in the facility, and any issues with the youth. One staff provided meetings are not valuable or informative and should be more detailed about what is going on in the facility. Staff were also questioned if they are briefed on any annual reports and/or youth and parent/guardian survey results. Four staff replied no and the remaining one staff replied yes. Staff believe communication for the most part is good at the program. One staff did provide the mental health staff does not tell the staff if there are issues with the youth. The PD stated, program administration gathers input from a variety of sources to ensure staff are informed of programmatic issues. Staff are provided opportunities to provide input and feedback into program operations. Procedures include a focus on staff retention, improving morale, and minimizing turnover. In addition, the program's management team will meet at least quarterly to assess the program's position regarding staff retention, morale, and overall operation of the program.

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

The program has a written policy and procedures in place to determine the program's system for evaluating staff, performance standards, and frequency of evaluations. A review of nine job/position descriptions demonstrated staff performance standards are clearly identified. Reviewed performance evaluations demonstrated they are completed, at a minimum annually, as outlined in policy. Staff are evaluated annually on established performance standards. The reviewed performance standards matched job descriptions for each staff. Key personnel, as outlined within the program's contract, are maintained and performed as outlined. The program director was interviewed and explained the annual evaluation process for staff. The program ensures a system for evaluating staff at least annually, based on established performance standards. Five staff were interviewed on the frequency for receiving a formal performance evaluation. Two staff reported never, two staff stated every six months, and two staff stated other and provided the response of the first one and every forty-five to ninety days.

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

The program's activity schedule was reviewed for recreation and leisure activities. The activity schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth. A review of the logbook demonstrates the activities are documented according to the program's activity schedule. The program's written policy and procedure provides activities based on the developmental levels and needs of the youth in the program. Activities held at the program include a choice of leisure and recreation options. Youth are encouraged and afford the opportunity to verbalize varying types of activities. Observations were made of youth engaged in constructive use of leisure time. Activities appeared to promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program takes precautionary measures to prevent overexertion, heat stress, dehydration, frostbite, hypothermia, and exacerbation of existing illness, or physical injury. A water cooler was observed outside and accessible to youth if and when they need water. The program contract includes one recreational therapist position. The Department headquarters and contract management staff approved the hiring of the

recreational therapist position with the current credentials of a bachelor's-level degree in psychology. A review of five youth records demonstrated the therapeutic activities provided is part of each youth's performance and/or treatment plan. The program has a formal process to promote constructive input by youth.

Five youth were interviewed and each agreed there are physical activities and leisure activities provided at least one hour. Youth described the activities as football, basketball, dodgeball, kickball, weight lifting, and running. Each of the youth confirmed they are provided with varying degree of mental and physical exertion throughout the day. Five staff were interviewed and each provided an example of the time and types of indoor and outdoor activities are provided to the youth.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures ensuring each youth's parent/guardian is contacted by telephone within twenty-four hours and in writing within forty-eight hours of the youth's admission to the program. The program is also required to notify the youth's committing court, assigned juvenile probation officer (JPO), and post-residential counselor (if applicable) within five working days of the youth's admission. A review of five youth case management records determined each youth's parent/guardian was contacted by telephone within twenty-four hours of admission and each record contained documentation confirming the youth's parent/guardian was notified in writing, within forty-eight hours of admission. All five records documentation indicating the JPO, post-residential counselor (if applicable), and court were notified of the youth's admission the same day the youth was admitted to the program.

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

The program has a policy and procedures regarding the provision of an orientation to each youth admitted to the program which is to begin the day of or prior to the youth's admission to the program. A review of five youth case management records found each of the youth were provided an orientation to the program the same day the youth were admitted to the program. A review of the youth handbook provided to each of the youth upon admission found all the required topics included the program's rules, procedures, schedules, and services provided to the youth. In addition to the youth handbook, youth were provided information regarding emergency procedures, assignments to living units, treatment teams, staff advisors, youth groups, and the daily schedule. A youth admission was unable to be observed during the annual compliance review, as there were no new youth admitted to the program. Each of the five interviewed youth reported receiving an orientation to the program the same day they were admitted to the program.

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

The program has a policy and procedures ensuring 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 screenings, assessments, or treatments. A

review of five youth case management records found one youth was eighteen years of age or older; therefore, two additional records were reviewed. Each of the three applicable records contained an Authorization for Release of Information to Parents/Guardians form, which allows the program to correspond with the youth's parent/guardian.

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

The program has a policy and procedures on the utilization of a classification system which promotes the safety and security, as well as the effective delivery of treatment services. The initial classification of youth is used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor. A review of five youth case management records found each youth's initial classification was completed on the day of their admission to the program. The initial classification forms contained all required elements. Each classification form also included a review of each youth's possible risks including suicide, mental health, medical, and escape risks. The program's policy and procedures also require the youth to be screened for vulnerability to victimization and sexually aggressive behavior prior to receiving a room assignment. All five records documented a Victimization and Sexually Aggressive Behavior (VSAB) form was completed in the Department's Juvenile Justice Information System (JJIS) prior to assigning the youth to a room. Two youth were identified as having medical alerts during the initial classification; however, these alerts were not entered into JJIS at the time of admission.

The program's policy and procedures ensure youth are reassessed and reclassified, if warranted, prior to considering the youth for an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools or instruments which may be used as potential weapons or means of escape, or participation in off-site activities. All five reviewed records confirmed reassessments were completed after the youth's initial thirty-days in the program and prior to an increase in the youth's movements or freedom of movements and participation in work projects and off-site activities. An interview with the executive director found the program utilizes a classification system, in accordance with Florida Administrative Code, promoting safety and security, as well as effective delivery of treatment services. The initial classification is used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor.

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 case management records reviewed were applicable for youth with gang affiliation; however, the program provided two additional applicable records for review.

Documentation found in both records indicated upon identification, local law enforcement was notified of each youth's suspected gang activity. Although the youth's local (home county) law enforcement was not notified in either of the records, both records documented the youth's educational providers, juvenile probation officers, and post-residential counselors (if applicable), were all notified of the suspected gang activity. Each of the youth had gang alerts entered into 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 case management records reviewed were applicable for youth with gang affiliation; however, the program provided two additional applicable records for review. Both youth participated in gang prevention and intervention activities. A review of sign-in sheets confirmed each of the youth completed a cohort of Impact of Crime (IOC). The program had a guest speaker visit the program twice during the annual compliance review period. The guest speaker covered topics including gang awareness, being a gang member while in jail, life and death situations while in jail, and daily events which occurred while in jail. Both youth's performance plans included relevant goals and objectives relating to gang intervention strategies.

2.07 Residential Assessment for Youth (RAY) Assessments and Re-Assessments	Limited 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 ensuring each youth receives an initial assessment within thirty days of admission. The program is to maintain all documentation of the initial assessment in the Department's Juvenile Justice Information System (JJIS). A review of five youth case management records found each youth had a Residential Assessment for Youth (RAY) completed in JJIS within thirty days of admission.

The program's policy also requires each youth to receive a RAY Reassessment within ninety days of the initial assessment, or when deemed necessary by the intervention and multidisciplinary treatment team. Three of the five reviewed records contained RAY Reassessments which were completed late. Documentation indicated the RAY Reassessments were completed thirty-nine, forty-nine, and seventy-four days late, respectively. The Ray Reassessments reviewed in the remaining two records found the reassessments were completed within ninety-days of the initial assessment, as required. All RAY Reassessments were maintained in the youth's record.

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

The program has a policy and procedures ensuring a Youth Needs Assessment Summary (YNAS) is completed within thirty days of each youth's admission to the program. A review of five youth case management records determined each youth had a YNAS completed within thirty-days of admission. Each YNAS was documented in the Department's Juvenile Justice Information System (JJIS), as required.

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

The program has a policy and procedures regarding the development of performance plans, goals, and transmittal. Four of the five reviewed case management records found the youths' performance plans were developed within thirty days of the youths' admission to the program. The remaining youth's performance plan was completed one day late. All five performance plans were developed after the initial assessments were completed. Each record documented the youth, treatment team leader, representatives from administration, living unit, staff from education, mental health, and medical were present during the development of each youth's performance plan. All five plans were signed by the youth, intervention and treatment team leader, and all parties who have significant responsibilities in goal completion. Two of the five plans contained signatures from the youth's parent/guardian and the remaining three records contained documentation indicating the plans were mailed to the parents/guardians; however, were not returned.

All five performance plans contained the youth individualized goals and were based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process. Each of the plans addressed the youth's top three criminogenic needs and specific delinquency interventions with measurable outcomes. Each of the plans identified program staff and youth responsibilities in accomplishing each of the goals, as well as target completion dates. Three of the five records contained documentation indicating copies of the plans were sent to the youth's committing court, juvenile probation officer (JPO), and parent/guardian within ten days of completion. One record was sent one day late. The remaining record indicated a copy was sent to the youth's parent/guardian but not to the committing court or JPO.

Interviews with five youth indicated each of the youth participated in the development of their performance plan and has a copy of the plan. Four of the five youth were able to remember the goals they were working towards, while one was not.

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

The program has a policy and procedures regarding performance plan revisions. Performance plan revisions are completed when deemed necessary by the intervention and multidisciplinary treatment team. Four of the five reviewed performance plans were revised due to Residential Assessment for Youth (RAY) Reassessment results. One plan required revisions due to newly acquired information. Four of the five plans were revised due to progress or lack of progress towards completing goals. One performance plan was revised in November 2019 but did not indicate progress or lack of progress on some goals, which had due dates of August and September 2019. Two of the five performance plans were revised, when needed, to facilitate transition activities during the last sixty days of the youth's stay at the program, as required.

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

The program has a policy and procedures on the completion of performance and release summaries. A review of five youth case management records found four of the five youth did not have performance summaries completed every ninety days, as required. One youth had a summary completed twenty-three days late and three youth were each missing one ninety-day performance summary. The completed summaries contained the status of each youth's performance plan goal, the overall treatment progress, the youth's academic progress, behavior, readiness to change, interactions with peers and staff, behavior adjustment to the program, positive and negative events, and if applicable, justification for release. The youth are allowed to read and add comments prior to signing the summary and are then provided a copy of the completed summary. The original performance summary was maintained in the youth's case management record and contained all required signatures.

A review of three closed youth case management records found release summaries were completed, as required in two records. One release summary was completed within thirty-eight days prior to the youth's anticipated release date, instead of the required forty-five days. Each of the three records were missing documentation indicating the parent/guardian was provided written notification of the youth's planned release once approved by the court. Two of the three records included a Residential Assessment for Youth (RAY) exit assessment. None of the records required victim notification. All five interviewed youth reported they were provided a copy of the performance summary which was sent to the court.

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

The program encourages each youth's parent/guardian to participate in the youth's case management and treatment services. Upon admission, each youth's parent/guardian is mailed a letter which includes a brochure and handbook which describes the services offered to the youth at the program. Included in the letter are the dates and times of the youth's treatment team meetings. Parent/guardians are encouraged to participate in person; however, if this cannot be arranged, parent/guardians may participate by telephone. A review of five youth case management records determined each youth's parent/guardian was sent an admission letter, brochure, and handbook. Each of the records contained documentation indicating the youth's parent/guardian was involved in the youth's assessment process, participated in the development of the youth's performance plan, received progress reviews, and participated in formal treatment team meetings, when available.

During the annual compliance review, two formal treatment team meetings were observed. The case manager attempted to make contact with each youth's parent/guardian but was unsuccessful; however, a voicemail was left for each of the parent/guardians requesting a call back with any questions or comments regarding their youth. An interview with executive director revealed parent/guardians are mailed multiple treatment team meeting feedback forms to provide their input on what they believe their youth can work on while at the program. Parent/guardians are also called monthly for treatment team meetings to express any questions or concerns they may have about the youth's treatment plan and behavior in the program. Each of the five interviewed youth reported their parent/guardians participate in treatment team meetings by telephone every month.

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

The program has a policy and procedures regarding members of the treatment team. According to policy and Department Rule, the treatment team is to be comprised of the youth, representatives from the program's administration, residential living unit, education staff, and others directly responsible for providing or overseeing the provision of intervention and treatment services to the youth. A review of five youth case management records found treatment team members included the youth, treatment team leader, a representative from administration, staff from treatment and education, recreational therapist, and the youth's juvenile probation officer and parent/guardian. While the living unit does provide written feedback, none of the records included documentation the living unit representative participated in person. A review of the treatment team meeting documentation also found there is not a signature line for the living unit representative. Observations of two treatment teams also confirmed the living unit representative was not present or participated in the treatment team.

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 the youth's performance plan. Each of the youth's performance plans incorporated additional plans including the youth's academic and mental health plans. None of the youth required a Department of Children and Families care plan.

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

The program has a policy and procedures ensuring formal treatment team meetings are held for each youth every thirty days. A review of five youth case management records found formal treatment team meetings were held every thirty days for each youth and informal meetings were held bi-weekly, as required. Documentation for each of the formal and informal treatment team review meetings included the youth's name, date of review, comments from treatment team members, a brief synopsis of the youth's progress, performance plan revisions, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, and Residential Assessment for Youth (RAY) Reassessment results.

A review of individual treatment team documentation found the first youth to have two formal and two informal treatment team meetings which did not contain progress on performance plans goals.

The second youth had two formal and two informal treatment team meetings which did not include living unit representative feedback and one treatment team form identified performance plan goals as "improved/continued;" although, the revised performance plan marked the goals as completed.

The third youth had two formal and two informal treatment team meetings which did not include living unit representative feedback, negative and positive behaviors, or physical interventions, and one treatment team form identified performance plan goals as "improved/continued" although the revised performance plan identified them as "past due."

The fourth youth had three formal and three informal treatment team meetings which did not include progress on performance plan goals; although, the next meeting indicated the goals were completed.

The fifth youth had one formal and one informal treatment team meeting which did not include living unit representative feedback and had a revised performance plan which identified six goals as successfully completed; although, documentation for two subsequent treatment team meetings identified these as "improved/continued."
Documentation on most treatment team meeting forms reflected limited detail on progress related to performance plan goals with most meetings identifying all goals as "improved/continued" with no other additional information.

Observations of two youth treatment team meetings found all required parties were in attendance with the exception of the living unit representative. Written feedback from the living unit representative was provided and read aloud by the case manager. The case manager attempted to contact both youth's parent/guardians; however, they were unable to be reached. Additionally, all topics were discussed, as required, with the exception of progress on the performance plan goals. All members of the treatment team were actively involved in the meetings and the youth were provided opportunities to demonstrate skills acquired at the program.

Four of five interviewed youth reported staff review their performance to include progress on performance plan goals, positive and negative behaviors, and treatment progress. One youth reported staff did not review this information during treatment team meetings. Four of the five youth reported receiving the opportunity to demonstrate any skills learned while at the program during treatment team meetings. The remaining youth reported not given this opportunity.

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

The program provides Type 3 career educational programming. Three closed youth case management records were reviewed. Each of the records contained a sample of completed employment applications, résumé, and documentation indicating the youth's parent/guardian and juvenile probation officer were aware of the youth's vocational plan. All records contained contact information for the youth's local Career Source Center; however, the information included the contact name, telephone number, and was missing the addresses and business hours. Two of the three records contained the appropriate documents essential to obtaining employment including the youth's birth certificate, state-issued identification card, and social security card. The third record documented the youth's parent/guardian refused to provide these documents to the program. An interview with the lead teacher revealed youth are offered My Career Shines, Employability Skills PEAK ALS, and Life Skills PEAK FuelEd assessments and services at the program. The executive director reported career/vocation services offered at the program include learning to run a fork-lift (for youth over the age of eighteen), SafeServe, employment, web design, business start-up, public speaking, résumé prep, and dining etiquette.

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.	

A review of documentation confirmed youth receive educational or career-related programming 250-days a year, with ten days used for teacher planning or training. Reviewed documentation including program logbooks confirmed youth received a minimum of twenty-five hours of instruction weekly, with minimal interference during the annual compliance review period. Youth are able to receive credit for any education or vocational training completed while at the program. An interview with the lead teacher found youth attend six, fifty-minute classes from 7:30 a.m. to 1:50 p.m., Monday through Friday. All five interviewed youth reported there are few interruptions during educational instruction.

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

Three closed youth case management review records were reviewed for education transition plans. Each of the records documented the educational transitional plans were developed based on the youth's post-release goals beginning at admission. All plans identified the youth, the youth's parent/guardian, instructional personnel from the program, Department personnel, and personnel from the post-release school district as key participants related to transition activities. Each of the plans were developed with the youth and program, education, and aftercare staff with specific plans for continuation of education and/or employment. All three plans included services and interventions based on the youth's assessed educational needs and post-release educational plans, recommended post-release placement, and specific monitoring responsibilities for individual responsible for the reintegration and coordination of the provision of support services.

Each of the records contained a sample of completed employment applications, résumé, Career Source Center contact information and documentation indicating the youth's case manager and parent/guardian were award of the youth's education transition plan, documents, and post-release discharge plans. Two of the three records contained the appropriate documents essential to obtaining employment, including the youth's birth certificate, state-issued identification card, and social security card. The third youth's parent/guardian refused to provide this information to the program.

2.19 Transition Planning, Conference, and Community Re-entry Team Meeting (CRT)	Failed 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.*	

The program has a policy and procedures addressing transition planning, conferences, and Community Re-Entry Team (CRT) meetings. A review of three closed youth case management records found each youth had a transition conference held at least sixty days prior to their targeted release date. Documentation of the transition conferences revealed the youth, treatment team leader, and other team members participated in the conference. None of the records documented participation by the executive director or designee. The signature line documented "N/A" on each form. Each record documented the youth's juvenile probation officer (JPO), parent/guardian, education staff, and any other additional pertinent parties were invited and encouraged to participate in the youth's transition conference. If participants were unable to

participate in person, a telephone conference line was utilized or they could provide written input.

Documentation reviewed from each of the three transition conferences revealed participants reviewed the youth's projected release date, release conditions, restitution, court fees, community service hours, and court-ordered sanctions. Documentation did not indicate the youth's performance plan, target goal completion dates, or persons responsible for goal completion were reviewed during the meetings. The forms also did not capture the signed signatures of attendees, acknowledging their accountability for the goals. None of the three records had documentation indicating a copy of the plan was sent with a request for return with signature to anyone not in attendance who had responsibility for completion of transition goals.

All three records documented a CRT meeting was conducted prior to the youth's release. Each of the records contained an email invite, inviting the case manager and youth to participate in the meeting. Documentation in each of the records indicated the youth and case manager participated in the CRT meeting.

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

Three closed youth case management records were reviewed for exit portfolios. None of the records had documentation indicating the exit portfolios were discussed or initiated at the transition conferences. All three exit portfolios contained a copy of the youth's transition plan, educational records/documents, school transcripts, résumé, and a sample of completed employment applications. Two of the three portfolios contained a state-issued identification card. The remaining youth record had documentation indicating the youth's parent/guardian did not provide the youth's birth certificate until two days prior to the youth's release from the program; therefore, an identification card was unable to be obtained. All three portfolios contained a calendar for appointments in the community after release; however, two of the three calendars did not include the dates or times for the appointments and the third calendar was missing one of the three required appointments. Two of the three portfolios included the youth's social security card and birth certificate. The remaining record documented the youth's parent/guardian refused to provide these documents to the program. Two of the three portfolios included education and/or vocational certificate(s) the youth earned while in the program; however, there was no documentation in the third record indicating the youth completed any certifications while in the program.

Each of the three records had documentation indicating the youth's exit portfolio was verified at the exit conference, the exit portfolio was provided to the youth upon release, and the program forwarded the exit portfolio information to the youth's juvenile probation officer.

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.	

The program has a policy and procedures addressing exit conferences. Three closed youth case management records were reviewed for exit conferences. Reviewed documentation indicated the exit conferences were conducted after the program notified the youth's juvenile

probation officer (JPO) of the youth's pending release and at least fourteen days prior to the youth's release date. The exit conference documentation in each of the records documented the date, signatures or names, if participating by telephone, and a summary of pending transition goals. A review of the Department's Juvenile Justice Information System (JJIS) found the admission and termination dates correlated with those documented in each youth's record. All three records documented a review of the status of the youth's transition activities established at the transition conference and finalized plans for the youth's release. Each of the three records documented the youth, education representative, JPO, and other pertinent parties participated in the exit conference. Two of the three records documented the youth's intervention, treatment team leader, and parent/guardian participated in the conference. All records documented the exit conference was conducted separately from the transition and Community Re-Entry Team meetings.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor who serves as the program's designated mental health clinician authority (DMHCA) and the director of clinical services. The DMHCA holds a clear and active license in the State of Florida, with an expiration date of March 31, 2021.The DMHCA is on-site full-time, working Monday through Friday from 9:00 a.m. to 5:00 p.m. The DMHCA is on-call twenty-four hours a day, seven days a week, and is responsible for the coordination and implementation of mental health and substance abuse services at the program. The DMHCA is also responsible for ensuring youth receive evidence-based group therapy from qualified and supervised clinicians, receive the required Standardized Program Evaluation Protocol (SPEP) services, as well as supplemental specialty services to address each youth's unique clinical needs. In addition, the DMHCA facilitates group counseling sessions and assists with family, individual, and/or supportive sessions as needed. The DMHCA facilitates the crisis stabilization of youth, as needed and facilitates staff training and drills. The DMHCA participates in weekly meetings with the psychiatrist to discuss youth receiving services and conducts quarterly mental health drills to ensure all staff participate. An interview with the DMHCA confirmed their role in the coordination and implementation of mental health and substance abuse services. A review of the position description indicates the DMHCA acts as the program's mental health and substance abuse authority.

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

The program does not have other licensed mental health/substance abuse staff other than the licensed mental health counselor who serves as the program's designated mental health clinician authority; therefore, this indicator rates as non-applicable.

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

The program has four non-licensed therapist positions. Three of the four non-licensed therapists are master's-level with degrees in social work, mental health counseling, and/or human services. One non-licensed therapist is a bachelor's-level with a degree in psychology and at least two years' experience assessing, counseling, and treating youth with emotional disturbance and/or substance abuse. Two of the non-licensed master's-level staff are registered clinical social worker interns and one non-licensed master's-level staff is a registered mental health counselor intern. All four staff work under the direct supervision of the designated mental health clinician authority (DMHCA). A review of the clinical supervision logs from August 2019 through February 2020 found the non-licensed mental health staff received at least one hour of face-to-face direct supervision from the DMHCA each week. The reviewed documentation found the program utilized their own clinical supervision log which included all required elements, as outlined in Chapter 397, Florida Statutes. The reviewed forms reflected a review of the clinician's case load, clinical services provided, documentation, miscellaneous directions, instructions, and recommendations. Training records for the four non-licensed staff validated each have completed the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included the administration of five assessments of suicide risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk (ASR).

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

The program maintains a written policy and procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The policy outlines the pre-screen process by which a youth's individualized history is reviewed and an admission screening is completed. A review of five youth mental health and substance abuse records found the program administered a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) screening on the day of admission. Each reviewed record documented the review of available information to include the commitment packet, reports, and records of existing documentation of mental health or substance abuse problems on the program's document review form. A review of five staff training records confirmed each record contained screenings administered by trained mental health staff working under the direct supervision of the licensed DMHCA. Each of the five reviewed MAYSI-2 screenings was completed in full and scored using the Department's Juvenile Justice Information System (JJIS). None of the five reviewed records indicated the need for further assessment based on screening results; however, an override was completed in four of the five MAYSI-2 screenings and the need for further assessment was clearly checked on each form. One form did not indicate a need for further assessment and there was no override completed; however,

documentation supported the youth received further assessment based upon prior alerts entered into JJIS. The program's practice is to refer all newly admitted youth for a comprehensive evaluation. Youth with an elevated risk of suicide are referred for an Assessment of Suicide Risk (ASR) regardless of MAYSI-2 screening results utilizing a mental health referral form. None of the five reviewed records were applicable for requiring immediate attention due to an identified crisis or emergency based on the MAYSI-2 screening results. An interview with the program's executive director reported youth undergo a standardized screening process upon admission which includes the review of the youth's commitment packet and the administration of the MAYSI-2.

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

The program maintains a written policy and procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The policy outlines the process by which all youth are referred to a mental health service provider for the completion of a comprehensive mental health and substance abuse evaluation. The program's policy is to complete a new bio-psychosocial evaluation/ assessment regardless of identified needs for each new admission. A review of five youth mental health and substance abuse records found four received a new evaluation completed within thirty days of admission. One evaluation was completed five days late. Each of the five reviewed evaluations were completed by a master's-level clinician working under the direct supervision of the licensed designated mental health clinician authority (DMHCA). All five evaluations were reviewed and signed by the DMHCA within ten calendar days, as required. Each new bio-psychosocial evaluation contained identifying information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, procedures administered, discussion of findings, diagnostic impressions, and recommendations. Three of the five reviewed records were applicable for a substance abuse diagnosis and contained a substance abuse assessment which was incorporated in the bio-psychosocial evaluation. Each record documented a consent for substance abuse services and urinalysis dated the day of admission. An interview with the program's DMHCA reported, assessments are completed upon admission and throughout treatment as needed. The DMHCA further explained the initial assessment, as well as the follow-up assessment results, are included within the comprehensive mental health and substance abuse evaluation. Comprehensive evaluations also include parent/guardian interview information, the youth's juvenile probation officer interview information, and a summary of the youth's initial behaviors exhibited at the program.

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

The program maintains a written policy and procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program's mental health and substance abuse plan indicates mental health and substance abuse treatment services are available to all youth at the program who are determined to meet clinical criteria. Additionally, mental health and substance abuse treatment is provided on-site through the provision of mental health treatment overlay services (MHOS). The program is licensed under Florida Statute, Chapter 397, and certified through the Florida Department of Children and Families (DCF) to provide substance abuse services for adolescents. The license expires on August 4, 2020.

Each newly admitted youth is assigned to a multidisciplinary intervention and treatment team within the admission intake and classification process. The program's treatment team assists the primary therapist in the development, review, and updating of initial and individualized treatment plans. A review of five youth mental health and substance abuse records supported each youth was assigned to a treatment team on the day of admission; however, there was no documentation to support the treatment teams included a living unit representative. Each of the five reviewed records contained a current Authority for Evaluation and Treatment (AET) form, a substance abuse treatment consent form, and a urinalysis consent form. Each of the five reviewed mental health records contained notes which included all elements of the Department's Counseling/Therapy Progress Note form. Weekly progress notes are maintained by an assigned counselor for each youth. Each reviewed weekly progress note form contained youth identifying information, date of services, start and end time of services, type of service, number of participants, curriculum, clinical interventions, youth response, summary of overall progress in treatment for the week, goals addressed during the week, summary of significant events, summary of family involvement, and the primary counselor's signature. A review of five youth mental health and substance abuse records supported youth received mental health and substance abuse treatment, as prescribed.

An interview with the program's designated mental health clinician authority (DMHCA) reported mental health and substance abuse services are tracked through each youth's weekly progress note. All clinical groups are facilitated by the program's trained master's-level mental health staff. Mental health groups include Impact of Crime; Harm to Victims, The Council for Boys and Young Men, Aggression Replacement Training; Anger Resolution, Cannabis Youth Treatment, Structured Psychotherapy for Adolescents; Responding to Chronic Stress Model, and mental health overlay services groups, as required. Four interviewed youth reported participating in group counseling at the program. One youth stated the completion of their groups. Five interviewed direct-care staff reported only therapists facilitate groups. Observations of mental health and substance abuse groups during the annual compliance review week and reviewed sign-in sheets reflected mental health groups had no more than ten youth, and substance abuse groups had no more than fifteen youth, as required.

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

The program maintains a written policy and procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. Treatment planning includes an initial mental health and substance abuse treatment plan, an individualized mental health and substance abuse treatment plan, monthly treatment plan reviews, and discharge planning. A review of five youth mental health and substance abuse records found an initial treatment plan was developed on the day of admission for four of the five youth. One initial treatment plan was developed five days late. Each initial treatment plan was documented on the program's form and contained all elements outlined in the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Four reviewed initial treatment plans were completed by a master's-level therapist working under the direct supervision of the licensed designated mental health clinician authority (DMHCA) and one was completed by the DMHCA. The DMHCA signed the plans completed by non-licensed staff within ten calendar days, as required. Each reviewed initial treatment plans were signed by the therapist developing the plan. None of the five reviewed initial treatment plans were applicable for psychiatric needs or prescribed medication and medication monitoring frequency.

A review of five youth mental health and substance abuse records found each contained an individualized treatment plan documented on the program's form containing all elements in the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. Each individualized treatment plan included youth identification information, youth Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, youth and family strengths, needs, ability preferences, services to be provided, clinical goals, youth interpretations of clinical goals, objectives, status, target completion dates, progress summary, summary of additional services, youth overall progress in the program, medication details where applicable, and treatment team member signatures. One of the plan did not document services and dosage but was updated to include this information during the first review. Four reviewed plans were developed within thirty days of admission and signed by the mental health staff creating the plan, the case manager, and the executive director. One plan was developed five days late. None of the reviewed individualized treatment plans documented a signature of a living unit representative. One was missing the signature of the program's administrative representative. Four of the reviewed individualized treatment plans were completed by a non-licensed mental health staff. Reviewed documentation confirmed the signature of the licensed DMHCA within ten days, as required. None of the five reviewed records were applicable for psychotropic medication monitoring. An interview with the program's DMHCA reported each youth's individual record is reviewed, the youth and parent/guardian are interviewed, and a comprehensive assessment is completed prior to the development of each individualized treatment plan.

Five youth mental health and substance records were reviewed for individualized treatment plan reviews. Each individualized treatment plan review was documented on the program specific form containing all the information in the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form. Each plan clearly documented identifying youth information, DSM-5 diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, clinical goals, youth interpretations of clinical goals, objectives, status, target completion dates, progress summary, summary of additional services, youth overall progress in program, medication details if applicable, and services to be provided. A total of twenty-two treatment plan reviews were applicable in the five youth records. Each of the twenty-two reviews contained signatures of required treatment team members participating in the review; however, none contained signatures of a living unit representative. An interview with the DMHCA reported within thirty days of the development of each individualized treatment plan, every youth receives a treatment plan review during which their goals and objectives are reviewed and updated.

Three closed youth records were reviewed for the completion of Mental Health/Substance Abuse Treatment Discharge Plans. Each record contained a discharge plan documented on the program's form and included all elements outlined on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form. Each of the three reviewed discharge plans were completed by the individualized treatment team on the same day of each youth's exit staffing. Each youth's discharge summary documented services needed and documented youth and parent/guardian participation. One of the discharge plans documented participation in counseling upon release; however, this was not discussed at the exit conference. None of the records were applicable for notification of suicide risk upon discharge. The program's practice is to obtain the parent/guardian signature on the discharge plan upon the youth's release from the program. The parent/guardian is then provided with a copy of the plan. The program also sends all Mental Health/Substance Abuse Treatment Discharge Plans to the youth's juvenile probation officer (JPO) by mail upon release.

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

A review of the program's contract and clinical program description indicated mental health and substance abuse treatment services are available through the provision of mental health overlay services (MHOS). Each youth is assessed upon admission for mental health and substance abuse needs utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). The program maintains a current Chapter 397 outpatient substance abuse license through the Department of Children and Families with an expiration date of August 4, 2020. The program's specialized mental health and substance abuse treatment services include monthly individual therapy and family therapy sessions and daily group therapy sessions. Mental health and substance abuse groups include Impact of Crime; Harm to Victims, The Council for Boys and Young Men, Aggression Replacement Training; Anger Resolution, Cannabis Youth treatment, and Structured Psychotherapy for Adolescents; Responding to Chronic Stress Model. Supportive counseling is available and provided on an as-needed basis. The program's clinical staff also provides initial screenings, clinical interviews, assessments, and evaluations, record review, bio-psychosocial evaluation, medical/psychiatric services, functional behavioral assessments, treatment plan development, daily therapeutic activities, and behavior modification. A review of five youth mental health and substance abuse records validated each youth received individualized mental

health services and substance abuse services, if applicable. Each session addressed mental health and/or substance abuse needs and was documented on the Weekly Progress Note form. The documentation supported the types of service the youth received which included the clinical intervention and the youth's response. A review of each therapist's caseload validated each had an average of nine youth, with none exceeding twelve youth. The program utilizes a licensed psychologist when necessary from the Escambia County School Board. The program reported not having any incidents during this annual compliance review period whereby the psychologist was needed.

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

The program maintains an independent psychiatrist agreement with a State of Florida board certified licensed psychiatrist commencing on March 19, 2019. The agreement was signed and dated by the psychiatrist on March 20, 2019 and the program's executive director on March 19, 2019 respectively. The psychiatrist's license expires on January 31, 2022. Routine services include psychiatric screenings, assessments, and evaluations of youth upon admission and through referral by program staff. In addition, the psychiatrist provides medication evaluation and on-going monitoring of psychiatric medications. All youth on psychotropic medications are evaluated at least monthly.

The program's contract with the Department outlines the psychiatrist is required to be on-site four hours bi-weekly. A review of the attendance logs from August 1, 2019 to February 2020 reflected the psychiatrist providing on-site services bi-weekly, as required, every other Wednesday. Each reviewed attendance log documented the psychiatrist signed-in and signed-out accompanied with their signature. The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. The program does not utilize a psychiatric advanced practice registered nurse. Interview with the designated mental health clinician authority (DMHCA) and the psychiatrist indicated meetings occur bi-weekly on the day psychiatrist is on-site, typically on Wednesdays. The DMHCA briefs with the psychiatrist prior to the youth being seen for their follow-up psychiatric appointments and is present for any discussions between youth and the psychiatrist.

Any medication issues during formal treatment team are revisited in greater depth with the clinical director, the youth's primary therapist, and the youth to determine an appropriate course of action. When the psychiatrist is not physically on-site, communication occurs by completion of Mental Health Referral form, which documents behaviors and events necessitating psychiatric referral/evaluation. In the event of a more urgent matter, the psychiatrist is contacted by telephone.

A review of five youth mental health and substance abuse records found two applicable youth entering the program received an initial diagnostic psychiatric interview within fourteen calendar days of admission; therefore, one additional record was requested and reviewed. The program reported having no youth who were admitted on psychotropic medication. All three initial psychiatric evaluations were completed on the Department's Clinical Psychotropic Progress

Note (CPPN). One of the three reviewed youth records indicated the youth was prescribed and received psychotropic medications post admission and documented monthly face-to-face medication monitoring reviews and the corresponding CPPNs were completed, signed, and dated by the psychiatrist. The program's practice is to conduct a psychiatric evaluation for each youth referred by program staff. Three applicable reviewed youth records documented psychiatric services in each individual treatment plan including addendums related to psychotropic medications for one applicable youth. A second youth was prescribed psychotropic medication post admission; however, the parent/guardian declined. The program did not have any other youth taking prescribed psychotropic medication during the annual compliance review period.

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

The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedure. The MHSA plan was updated and approved by the program's executive director on February 3, 2020 and the designated mental health clinician authority (DMHCA) documented a review on February 3, 2020. The program's written plan detailed suicide prevention procedures and included all required elements as outlined in Florida Administrative Code. The plan outlined the identification and assessment of youth at risk of suicide through the screening or alert process and any time subsequently, as well as suicide precautions and the levels of supervision. The plan addressed the requirements for staff training as it relates to suicide prevention, the implementation of suicide precautions, and to recognize verbal and behavioral cues. The plan included the referral process, communication, notification, documentation, immediate staff response, and review process. In an interview, the program's executive director validated the program conducted quarterly mock drills for staff which include emergency response to suicide or self-inflicted injury. In addition, suicide prevention training is conducted for all pre-service staff and annually for all in-service staff. In an interview, the program's executive director stated mock emergency drills are completed at least quarterly, inclusive of mental health and suicide drills.

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

The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a suicide prevention plan to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. All youth admitted into the program shall be screened for suicide risk factors as part of the initial intake

and admission classification meeting process. The clinical therapists' complete screenings immediately upon intake and ensure the constant supervision of the youth throughout the intake process. A review of five youth mental health and substance abuse records supported each youth was screened for suicide risk utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). Three of the five youth had an elevated risk of suicide and was referred to mental health staff for completion of the Department's Assessment of Suicide Risk (ASR). All three ASRs were completed by non-licensed clinician and reviewed by the licensed designated mental health clinician authority. A review of four staff training records validated each non-licensed clinician completed the required twenty hours of ASR training and five supervised assessments under the direct supervision within the physical presence of a licensed mental health therapist. All three applicable youth were placed on precautionary observation (PO) due to self-reporting and staff observations. Parent/guardian and the assigned juvenile probation officer notification was documented. A review of the Department's Juvenile Justice Information System (JJIS) validated a suicide risk alert was initiated and removed, as required. Suicide precaution observation logs were completed for each youth while on PO. Supervision was documented on each log to include mental health staff supportive services. Each applicable youth received an ASR completed prior to the removal from PO and each ASR documented youth may be stepped down to standard supervision. Discontinuation of close supervision was documented in accordance with the program's suicide prevention plan; however, it was not documented in the program's logbook. The program does not utilize secure observation.

The program maintains one suicide kit which is stored in a locked cabinet in the main youth meeting room. Interviews with program administration and direct-care staff supported each have a key to open the cabinet. Observation of the suicide kit during the annual compliance review validated it contained a knife-for-life, wire cutters, and needle nose pliers. The kit was observed to be taped closed and very difficult to open. The kit is opened and reviewed monthly by the program's director of operations and the date of inspection is written on the tape. In addition, the program also maintains a knife-for-life, wire cutters, and needle nose pliers affixed to a wall in the medical clinic, and another knife-for life in the director of operations office.

The program's executive director has approved an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. The multidisciplinary review includes all required elements to include the circumstance surrounding the event, facility procedures relevant to the incident, relevant training, pertinent medical and mental health services involving the victim, precipitating factors, and recommendations.

Five interviewed staff reported when a youth expresses suicidal thoughts, direct staff are responsible for notifying mental health staff, search the youth and room for sharps, speak to the youth in private and notify the shift supervisor, and place the youth on constant supervision. Each interviewed staff was aware of the program's suicide response kit's location containing the knife-for-life, wire cutters, and needle nose pliers.

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

The program maintains a written comprehensive plan for mental health and substance abuse services detailing suicide prevention procedures. The suicide prevention plan establishes a

method by which suicide prevention services shall be provided to all youth. Three applicable youth mental health and substance abuse records were reviewed for suicide precautionary observation (PO). All three applicable suicide precautionary observation logs were documented on the Department's Mental Health and Substance Abuse form and contained all required elements. Each reviewed suicide precaution observation log was documented in real time and did not exceed thirty-minute intervals. There were no applicable warning signs documented. Each reviewed log documented the safe housing requirements and was reviewed and signed by the shift supervisor and by the designated mental health clinician authority. Interviews with three youth placed on precautionary observation confirmed while on suicide precautions, the youth were never left alone and staff were with them at all times.

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

A review of five staff training records found each staff completed two hours of suicide prevention training in the Department's Learning Management System (SkillPro) and four hours of instructor-led training. The program's comprehensive mental health and substance abuse plan outlines all staff will receive intensive training on suicide prevention. The training will consist of a thorough review of the suicide prevention plan and will include detention techniques, behavioral cues, and recommended responses. Staff are provided with an overview of recognizing signs and symptoms of emotional disturbance and mental health illness in children and adolescents. Lectures and practical application are used to address suicide precautions, levels of supervision, crisis response, and documentation. Training includes signs and symptoms and stages of suicide. Mock drills in response to suicide attempt and/or serious self-injurious behaviors are conducted once a quarter on each shift. Reviewed mental health drills reflected clinical drills simulating a youth suicide attempt were not conducted on any shift during the first quarter for the period of January 2019 through March 2019. The first drill was conducted on June 13, 2019. In addition, there were no mock suicide drills conducted on the third shift during any of the four quarters. Each reviewed drill documented the description of the mock incident and a synopsis of the response. There were no documented deficiencies identified and no applicable corrective action required. Each drill documented staff responded appropriately. Reviewed documentation supported mock drills which demonstrated life saving techniques such as cardiopulmonary resuscitation and use of the automatic external defibrillator were conducted during the second and fourth on the first and second shift. Participating staff signed the clinical drill participation log indicating their understanding and compliance with the procedures. Documentation reflected direct-care staff participated in mental health drills at least semi-annually. An interview with the program's designated mental health clinician authority reported if staff are unable to participate in a mock suicide drill, they are briefed on the drill during shift briefings; however, shift reports do not reflect drills are discussed.

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 maintains an integrated mental health crisis intervention and emergency mental health and substance abuse (MHSA) services plan detailing mental health crisis intervention services. The MHSA plan was updated and approved by the program's executive director on February 3, 2020 and the designated mental health clinician authority (DMHCA) documented a review on February 3, 2020. The program's comprehensive plan for crisis intervention services outlines response to youth in crisis in the least restrictive method possible and to protect the personal safety of the youth and others while maintaining control and safety of the program. The plan detailed crisis intervention procedures to include notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and the review process. Low level crisis intervention is typically provided by the program's direct-care staff and/or supervisor staff through interventions within the positive performance system, behavior management system. Youth demonstrating acute emotional, psychological distress, or behavioral issues are referred immediately to the mental health clinical staff for crisis intervention, assessment, and counseling. A youth can be placed on a mental health alert by direct-care staff and/or clinical staff when a youth is identified as having a mental disorder or acute emotional distress which may pose a safety/security risk. All mental health alerts shall be entered into the Department's Juvenile Justice Information System (JJIS) and shall be documented on the program's alert in the program's logbook.

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

The program has a policy and procedures addressing crisis assessments. Five youth mental health and substance abuse records were reviewed. One youth was applicable for requiring a crisis assessment on two separate occasions. The program reported not having any other youth requiring a crisis assessment during this annual compliance review period. On January 23, 2020, the youth was determined to be in crisis and a crisis assessment was completed. The crisis assessment included the determination of danger to self and/or others, initial clinical impressions, supervision recommendations, recommendations for further follow-up or further evaluation, and notification to parent/guardian. The crisis assessment was conducted by a non-licensed clinician within two hours and reviewed by the designated mental health clinician

authority (DMHCA) on the same day. A mental health alert was entered into the Department's Juvenile Justice Information System (JJIS) and the youth was placed on constant supervision. Pursuant to an order written by the psychiatrist and consultation with the Department's Office of Health Services (OHS), youth was to remain on constant supervision pending further future scheduled examination. Documentation of constant supervision was recorded on the Department's Mental Health Alert-Observation Log; however, not documented in real time. There were fifteen incidents whereby there was no documentation to support the Mental Health Alert-Observation Logs were reviewed and signed by the shift supervisor. On July 23, 2019, the youth alleged a traumatic event involving a Prison Rape Elimination Act (PREA) incident while at the detention center awaiting placement in the program. Reviewed documentation found clinical staff referred the youth to the psychiatrist; however, there was no documentation to support a crisis assessment was completed or the youth offered ongoing mental health treatment services. The program followed all other PREA protocol regarding reporting and communication.

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 maintains an integrated mental health crisis intervention and emergency mental health and substance abuse (MHSA) services plan. The MHSA plan was updated and approved by the program's executive director on February 3, 2020 and the designated mental health clinician authority (DMHCA) documented a review on February 3, 2020. The emergency care plan included procedures for immediate staff response, notifications, communication, supervision, and authorization to transport for emergency mental health or substance abuse services. In addition, the plan outlined documentation requirements and staff training requirements to include recognizing signs and symptoms of emotional disturbance and signs and symptoms of substance abuse and mental health illness. The emergency care plan included procedures for immediate staff response, notifications, communication, supervision, and authorization to transport for emergency mental health or substance abuse services. The program utilized the Escambia County Sheriff's Office for transport. In addition, the plan outlined documentation requirements and staff training requirements to include recognizing signs and symptoms of emotional disturbance and signs and symptoms of substance abuse and mental health illness. The program utilizes Lakeview Center 1221 West Lakeview Avenue Pensacola, Florida for crisis stabilization Baker Act and Marchman Act.

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

The program maintains an integrated mental health crisis intervention and emergency mental health and substance abuse (MHSA) services plan inclusive of Baker and Marchman Act proceedings. The MHSA plan was updated and approved by the program's executive director on February 3, 2020 and the designated mental health clinician authority (DMHCA) documented a review on February 3, 2020. The program had two youth applicable for Baker Act proceedings and no youth applicable for Marchman Act proceedings during this annual compliance review period. A review of one Baker Act proceeding dated December 9, 2019 supported direct-care

staff notified the designated mental health clinician authority (DMHCA) and reviewed documentation found the DMHCA completed the required Certificate of Professional Initiating Involuntary Examination of Baker Act proceedings. The youth was placed on one-to-one supervision until transported to Lakeview Center by the Escambia County Sheriff's Office. Documentation supported the youth was placed on constant supervision upon return from Lakeview Center and an Assessment of Suicide Risk was completed by the DMHCA. The youth was maintained on constant supervision until stepped down to standard supervision by the DMHCA and program's executive director.

The program's policy states in the case a youth needs immediate evaluation and/or treatment and a licensed mental health professional is not available to initiate Baker Act procedures, local law enforcement will be called to initiate Baker Act procedures and transport. The policy further states the program will maintain precautionary observation with at least one-to-one supervision of the youth until transported by law enforcement. On January 7, 2020 a report was made to the Department's Central Communications Center indicating a youth was evaluated by mental health staff and transported to the hospital for a Baker Act. According to interviews with the program's director of operations and DMHCA who was not on-site during the incident, the youth was transported to the emergency room for evaluation for Baker Act proceedings by two program staff. Based on staff interviews and program logbooks, there was no indication law enforcement was contacted to initiate Baker Act proceedings. The DMHCA provided text messages from program staff indicating the youth may have ingested pills. In addition, there was no documentation to support the youth was placed on constant supervision while awaiting transport. Upon return from Lakeview Center, reviewed documentation found the youth was placed on constant supervision and an Assessment of Suicide Risk was completed by the DMHCA. The youth was maintained on constant supervision until stepped down to standard supervision by the DMHCA and program's executive director.

Standard 4: Health Services

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

The program maintains a written policy and procedures ensuring a health authority shall be responsible for the healthcare services provided. During the review period there were two different doctors serving as the designated heath authority (DHA). The current DHA services started at the program in September 2019. The previous DHA holds an active, unrestricted license under Chapter 458, Florida State Statute, with a license expiration date of January 31, 2021. The current DHA holds an active, unrestricted license under Chapter 458, Florida State Statute, with a license expiration date of January 31, 2022. The program was able to provide the independent contractor agreement with the previous DHA. The program could not provide the independent contractor agreement with the current DHA. There was one occasion when the DHA was not on-site and the duties were delegated to a different medical doctor acting on the behalf of the DHA. Due to the fact of the program's inability to provide the current contract with the current DHA, there was no way to document the medical doctor providing coverage was an appropriate replacement. The program does not utilize an advance practice registered nurse or physician's assistant. The DHA is scheduled to be on-site for approximately two hours weekly. Reviewed physician logs for the past six months supported the DHA was on-site weekly as required. Reviewed documentation supported the DHA maintained communication with program staff regarding youth medical needs and was available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. An interview with the DHA confirmed their role in providing medical oversight to the program. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist. The psychiatrist's license is current. The psychiatrist is on-site once a week and meets with the treatment staff to discuss the needs of the youth and evaluate medication management. The interview with the DHA supported they are available twenty-four hours a day.

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

The program maintains facility operating procedures for all health-related procedures and protocols utilized at the program. The program's assigned designated health authority (DHA) conducted an annual review of all health-related policies, procedures, and protocols. Reviewed documentation validated the DHA signed all healthcare policies and procedures on February 18, 2020. Reviewed documentation validated the program nurses reviewed the healthcare policies and procedures on various dates in the beginning of February 2020. The psychiatrist also reviewed applicable policies. The program could not provide the annual review of the health-related policies, procedures, and protocols reviewed and signed by the previous DHA from February 2019 through September 2019. The program was not able to provide the annual review of the health-related policies, procedures, and protocols by the current DHA from September 2019 through February 17, 2020. The program hired two new nursing staff since the last annual compliance review. The review team was provided with an orientation help guide for the two newly employed healthcare staff. There were no signatures or dates from the nurse who provided the training and no signatures of the staff receiving the training to support the training

was completed. The program maintains a nursing protocol manual and treatment protocols reviewed and approved by the current DHA.

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

The program maintains a written policy and procedures ensuring parent/guardians are authorizing specific treatment for youth. All five reviewed individual healthcare records (IHCRs) contained a legible copy of the Authority for Evaluation and Treatment (AET) and was marked "Copy". The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form. The authorization includes to whom the information can be released and shared. One of the five youth turned eighteen years of age while in the program. The youth signed a new AET. Each reviewed AET form was filed in each youth's IHCR. There were no youth in the custody of the Department of Children and Families. Each reviewed AET and/or Release of Information form was filed in each youth's IHCR in the appropriate section. An interview with nursing staff indicated the medical staff reviews and validates the AET upon the youth's admission.

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

The program maintains a written policy and procedures addressing parental notification and obtaining consent when new medications and treatments are prescribed. Five reviewed individual healthcare records (IHCRs) supported three were applicable for parental notification. Each of the three records were missing parental notifications. One youth turned eighteen years of age while in the program and signed the appropriate consent for eighteen years of age or older. Prior to the youth turning eighteen years of age, there was no parental notification for a medication discontinued and a pro re nata (PRN) medication ordered in October 2019. One youth was missing a parental notification when beginning a psychotropic medication. This same youth was missing parental notification when the youth went off-site to the emergency room. The third youth was missing parental notification when the youth received an x-ray, two separate visits to the podiatrist, and when a medication was ordered. The nurses maintained a document in each youth's IHCR where verbal consent was obtained for any over-the-counter (OTC) medication which has not been previously approved, new prescriptions, significant dosage change, or for discontinuing a medication. There were two youth records where there was an occasion when a staff member did not document as the witness to the nurses' verbal notification to the parent/guardian. Written notification was sent to the parent/guardian for pertinent medical events except for one occasion when the youth went to the emergency room. One youth was applicable for taking a psychotropic medication in which two additional records were requested. The reviewed records documented a telephone consent conducted by the psychiatrist and witnessed by the nurse. A copy of the Department's Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication was sent to the parent/guardian. Medical staff verified the youth's vaccinations within the first thirty days of admission. There were no applicable youth requiring immunizations; however, there was one youth who had a documented religious exemption from immunization. The program's practice is for the nursing staff to pull each youth's immunization record from the Florida Shots

website within the first week of admission and have the designated health authority document a review of the record. This practice was confirmed by the nursing staff in an interview.

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

The program maintains a written policy and procedures ensuring each youth receives a healthcare admission screening and youth receive a rescreening if the physical custody of the youth changes and they are subsequently returned or readmitted. A review of five youth individual healthcare records (IHCRs) supported each youth received an initial admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. Additional FEPHS forms were completed for all five of the youth by non-licensed staff; however, the program was unable to indicate why the additional screenings were completed. All FEPHS forms completed at the time of admission were completed by a registered nurse (RN). Two of the additional FEPHS forms were completed by direct-care staff and not reviewed by the licensed medical staff within twenty-four hours. One FEPHS was completed on February 2, 2020 by direct-care staff and was not reviewed by the RN until February 8, 2020. Another additional FEPHS was completed on January 26, 2020 by direct-care staff was not reviewed by the RN until January 28, 2020. An interview with the RN indicated youth are assessed by the medical staff on the youth's date of admission. The nursing staff completes the FEPHS and the DHA is notified when a youth with a serious or chronic condition is admitted to the program. During the interview with the DHA, it was indicated the DHA is not notified of all new admissions. The DHA indicated, the program notifies the DHA of the applicable youth requiring the notification but not all youth.

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

The program maintains a written policy and procedures establishing a system where all youth shall be oriented to the healthcare system upon admission. The program's facility operating procedure requires specific topics to be addressed during the youth orientation. The following topics are required by the policy but were not addressed in the orientation process such as notification to staff if youth are having side effects, the non-disciplinary role of healthcare providers, and situations in which the health care staff shall notify security. A review of five youth individual healthcare records (IHCRs) validated four of the five youth received a healthcare orientation on the day of admission. There was not an orientation packet in one of the youth's IHCR to support the youth was orientated to the health care system. The program provided a list of youth names and indicated to the review team the list was supporting documentation to substantiate the youth received the orientation; however, there was no date on the list to support when the orientation was provided or who provided the orientation pertaining to the healthcare services.

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

The program's practice for the designated health authority (DHA) is to be notified by telephone when a youth is admitted on prescribed psychotropic medications and youth admitted with medical conditions. A review of five youth individual healthcare records reflected the DHA was notified by telephone for two youth admissions even though the two youth did not have any medical conditions. One youth had a medical condition requiring DHA notification of admission. The nurse signed the bottom of the Intake Nursing Progress Notes; however, there is no documentation the DHA was notified on the date of the youth's admission.

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

The program maintains a written policy and procedures indicating nursing staff complete the Department's Health-Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). A review of five youth individual healthcare records supported a new HRH form was completed on the same day of each youth's admission. The designated health authority (DHA) documented a review of the HRH forms by signing the HRH form and documenting the review on the CPA. An interview with nursing staff confirmed the HRH is updated on the youth's date of admission or within seven days of admission.

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

The program maintains a written policy and procedures addressing the comprehensive physical assessment. A review of five youth individual healthcare records (IHCRs) reflected the program utilizes the Department's standardized Comprehensive Physical Assessment (CPA) form. Although the youth had a current CPA at the time of admission, the designated health authority (DHA) completed a new CPA during the admission exam. All CPAs were completed by the DHA. All sections of the CPA were completed in full utilizing "O" with no applicable "X" and included the appropriate medical grade with two exceptions. There were two youth where the Tanner Stage section of the CPA was left blank. One of the CPA forms also had two other questions left blank on the form with no indication from the DHA of the reason why the areas were left blank. Reviewed documentation confirmed the Department's Problem List was updated for each youth throughout their stay, when applicable.

The review of the five youth IHCRs confirmed each youth had a verified tuberculin skin test (TST) documented on the CPA within the last year. All tier I tuberculosis screenings were conducted on the day of admission for each youth. Reviewed documentation found the results of the TST were also documented on the Department's Infectious and Communicable Disease (ICD) form and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. Nursing interviews indicated nursing staff has a verification of the TST screening upon admission.

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

The program maintains a written policy and procedures ensuring all youth are evaluated and treated for sexually transmitted infections (STI). A review of five youth individual healthcare records (IHCRs) reflected each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. Based on the screening results, four of the five youth were referred to the designated health authority (DHA) for further evaluation and testing was ordered. There was documentation in three of the four records to support testing was ordered; however, there was documentation in all four of the records to support the testing was completed. There was one applicable youth who was out of the Department's custody and required a rescreening due to present symptoms. Documentation in the youth IHCR supported the rescreening was completed. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form for all four youth. The nursing interview confirmed the program's practice.

Documentation in all five youth IHCRs supported each youth was offered the opportunity to receive counseling and testing for human immunodeficiency virus (HIV). Three of the youth consented for testing. The program utilizes the acquired immune deficiency syndrome AIDS Foundation to provide pre-counseling, testing, and post-counseling. Reviewed youth IHCRs validated when youth received pre-counseling, testing, and post-counseling, the youth's Health Education Record form was updated. The results were placed in a sealed envelope marked "confidential" with the youth's name, test date, and the designated health authority's initials documented on the outside of the envelope. The nursing staff interview indicated the confidential results are provided during a private one-to-one education. All five interviewed youth stated they could ask and request a HIV/AIDS test.

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

The program maintains a written policy and procedures ensuring all youth shall be able to make sick call requests and have their complaints treated appropriately through the sick call system. Each day sick call is conducted at 3:00 p.m. which coincides with signs on the sick call box and in the medical room. The program activity schedule indicates sick call is conducted at 7:00 a.m. A review of five youth individual healthcare records (IHCRs) found all five youth completed a Sick Call Request form at least once during their stay. The registered nurse (RN) documented the treatment and/or services provided to the youth during the sick call event on the Sick Call Request form. The reviewed IHCRs indicated each sick call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed in the healthcare record. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. The program's policy indicates when a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into a shift supervisor for review. The shift supervisor will determine if the sick call requires immediate attention. There

was no documentation to support a shift supervisor was required to review any sick call requests. The contract requires sick call to be provided seven days a week. The program maintains a sick call box located in the day room hallway mounted to the wall. The box is monitored throughout the day by nursing staff. All youth are seen within twenty-four hours of submission; however, there was an exception when a youth filed a sick call on July 24, 2019 and was not seen by the nurse until July 28, 2019. During the sick call, the nurse identified themselves and stated why the youth was at the medical office. Training records supported the youth was escorted by a Protective Action Response (PAR) certified staff. The PAR certified staff was present during the exam while maintaining the youth's privacy. One sick call was observed with the youth's permission during the annual compliance review. Observations validated the youth was seen by a licensed medical professional in a confidential manner. Four of the five interviewed staff indicated the nurse responds to and conducts sick call. One staff indicated the doctor responds to and conducts the sick calls.

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

The program maintains a written policy and procedures addressing the comprehensive process for the provision of episodic care and first aid care. A review of five youth individual healthcare records (IHCRs) found two youth requiring episodic and/or first aid care several times during their stay in the program. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. The Episodic/First Aid Log contained documentation of incidents of care by date, name of youth, Department identification number, and injury/emergency. One youth IHCR contained a discharge document from the emergency room. There was no other documentation in the youth's IHCR to indicate why the youth went to the emergency room or the treatment the youth received while at the emergency room. There was no documentation to support the designated health authority was notified. The visit to the emergency room was not documented in the Episodic Log. There was documentation in a second youth's IHCR indicating the youth was seen by medical staff on January 12, 2020 for being punched in the face; however, there was no parental notification documented in the youth's record. All five interviewed youth indicated they are able to see a doctor or dentist if they have the need.

The program maintains two automated external defibrillators (AED) located in the medical room and the administrative hallway. The AED batteries will expire in March 2022 and August 2023 . The pads will expire on September and October 2021. The program maintains ten first aid kits located in various areas around the program and for each program vehicle. There were seven first aid kits which could not be opened without breaking the first aid kit. The program provided the review team documentation to support the kits were checked monthly by nursing staff to ensure each are adequately supplied and in operating order. An inspection of three first aid kits found required items were missing from each kit. The program maintains one suicide response kit located in the main dayroom area in a locked cabinet.

Reviewed training records found all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with automated external defibrillator (AED). Nursing staff maintained current certifications in CPR and AED.

During the review period, the program conducted emergency medical drills monthly on each shift. There was no documentation to support staff participated in the drills as required. One of the thirteen medical drills followed the required guidelines and contained the appropriate documentation about the drill. The program maintained a list of emergency telephone numbers located in the medical clinic and the administrative hallway accessible to staff but inaccessible to youth.

All five interviewed staff indicated they were aware of their right and responsibility to call 9-1-1 in case of an emergency.

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

The program maintains a written policy and procedures ensuring timely referrals and coordination of medical services to an off-site healthcare provider. Evaluations and events conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) is responsible for reviewing and signing the off-site care instructions. A review of five youth individual healthcare records (IHCRs) found three youth requiring off-site care and/or emergency care. Overall there were eight examples where the off-site care documentation was not filed. One youth was missing the off-site documentation for three visits to the dentist, one visit to the hospital, and one visit to the emergency room. Another youth was missing off-site documentation for two visits to the podiatrist and one trip to obtain an x-ray. There was documentation in all three records to support the youth received applicable follow-up testing, referrals, or appointments. One of the three youth records contained documentation to support the parent/guardian was notified of all the off-site care. The remaining two youth records were missing the parent/guardian notification. The off-site care documentation filed in the youth's IHCR was reviewed by the DHA as evidenced by the DHA signature and date. An interview with nursing staff indicated they track follow-up testing, referrals and appointments by conducting record checks and an appointment calendar.

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

The program maintains a written policy and procedures ensuring youth who have chronic conditions receive regularly scheduled evaluations and necessary follow-up treatment. Five youth individual healthcare records indicated one youth was admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. Two additional applicable IHCR were requested and reviewed. All three youth were classified with a medical grade of two through five.

One youth was undergoing treatment for a physical health condition. The remaining two youth were taking psychotropic medication. Reviewed records reflected each youth received periodic evaluations as required. All three youth had a specialized treatment plan included in the practitioner's orders located in each youth IHCR. The program maintains a tracking log of youth requiring periodic evaluations as required. The youth's Problem List was updated as required. There was no indication of lapses in care or missed periodic evaluations.

An interview with the designated health authority (DHA) indicated chronic conditions are monitored at least every sixty days and some conditions require more often. An interview with nursing staff reported youth identified with a chronic condition receive a periodic evaluation every two months or no less than once every three months.

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

A review of five youth individual healthcare records was conducted. None of the five youth entered the program taking medication. The medical staff indicated they did not have any examples of youth who entered the program taking medication. Three of the five youth were prescribed medication during their stay at the program. A comparison of nursing progress notes, practitioner orders, and sick calls were compared with the Medication Administration Record (MAR) to ensure medication and treatment was documented as required. The program utilizes a pre-printed pharmacy MAR to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. There were examples in all three youth IHCRs where the youth did not receive the medication as prescribed. There were blank days found on the MARs where the nurse did not document the medication was given to the youth. There was also documentation on the back of the MARs indicating the youth was not given their dose of prescribed medication because the youth was unavailable. The review team followed up with the nursing staff as to why the youth was unavailable. , The nursing staff was unable to provide an answer. The nursing staff indicated there are occasions when the youth are off-site during the prescribed dosage time. The nursing staff indicated if the youth was not on-site at the specific dosage time, the youth did not receive the dose of medication. The February MARs were reviewed for all youth currently in the program based on the fact all three reviewed youth had missing dosages of medication. There was a total of ten youth who missed doses of medication. These incidents were reported to the Department's Central Communications Center (CCC) throughout the week of the annual review. Nursing staff documented weekly side effect monitoring on the MAR with two exceptions. One youth's MAR had documentation to support side effects were monitored on December 3, 2019 and then on December 12, 2019 which was two days late. Another youth's MAR had documentation to support side effects were monitored on January 9, 2020 and then on January 17, 2020, which was one day late.

Observation of storage of medication during the annual review found all medications were stored in a separate, secure area of the medical room inaccessible to youth. All non-controlled medications and over-the-counter (OTC) medication was stored as required. During the week of the review, there were no narcotics or other controlled medications on-site. The program has a metal lock box located within the locked medical cart to store narcotics and controlled medications when necessary. Oral medications were not stored with injectable or topical medications. Medications requiring refrigeration were stored in a secure refrigerator which is only used for medication. Syringes and sharps were secured. The medication cart was observed to be clean, organized, and stocked items are stored separately from specific youth medications. All expired medication is destroyed once a month when the pharmacist visits the program.

All five interviewed staff indicated the nurse provides medication. Two of the five staff also indicated a supervisor provides medication. One staff indicated program staff are able to provide medication. Two staff indicated only trained staff are able to provide medication. All five interviewed youth indicated a nurse administers their medication and was able to describe the process.

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

The program maintains a written policy and procedures ensuring all medications shall be secured and inventoried. Observations made during the review week found the medical equipment classified as sharps were secured and inventoried using a routine perpetual inventory descending count. All medications were secured in a locked area designated for storage. The topical, liquid, and oral medications were stored separately as required. At the time of the review, there were no controlled substances on-site. Narcotics and other controlled medications are securely stored in the locked box located in the medication cart.
Medical staff were able to provide documentation to support when the program did have a controlled medication on-site, the perpetual inventory was maintained. Reviewed documentation and nursing interviews confirmed all over-the-counter (OTC) medications are inventoried at least weekly. A review of the program's counts from the past six months validated no discrepancies were identified with the counts. The medical staff reported destruction and disposal of medication is handled by the contracted pharmacy. The medication is returned to the licensed pharmacy technician for proper disposal. The program maintained a list of supervisory level, non-healthcare staff who were trained by a registered nurse to provide oversight of youth who self-administered their medication. A comparison was made of the documented inventory of two youth medications, three OTC medications, and three sharps with the actual number in stock. No exceptions were noted. A review of the program's inventories for the past six months supported inventories were maintained as required. Observation of the medication cart found it was clean and organized. The stock items were maintained separately from the youth's prescribed medication.

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

The program maintains a written policy and procedures ensuring there is an approved plan for exposure control and infection control. The exposure control plan provided to the review team was missing the first page. The following topics were not addressed in the plan: self-limiting/episodic/contagious illnesses, other outbreaks or epidemics caused by any other infectious agent, whether spread directly or indirectly, food borne illnesses such as those caused by E. Coli, and staff have access to protective equipment. The exposure control plan was signed by administration on January 20, 2020. The program was unable to provide documentation to support the plan was reviewed prior to January 20, 2020. There were no

documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review.

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

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

Standard 5: Safety and Security

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

The program maintains a written policy and procedures ensuring all program staff shall promote safety and security by maintaining active supervision of youth to include interacting positively with youth, engaging youth 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. The program has a daily youth activity schedule which was observed to be posted throughout the facility. Program staff are always required to account for the location of youth under their supervision and ensure staff-to-youth ratios are in compliance with contract requirements. A review of the contract supported staff-to-youth ratios during the day is one-to-eight and at night one-to-twelve. Off-site activity ratios are one staff to five youth; however, observations found two staff participated in the transportation of youth. Observations made throughout the annual compliance review week supported staff-to-youth ratios were maintained as required. Daily activities were observed to include classroom activities, line movement, meals, transportation off-site and return, groups, and outdoor activities. The program conducts formal and informal head counts and movements throughout each shift. Formal counts take place where movement stops and youth are accounted for by name and cross referenced with the census and documented in the facility's logbook. The program's procedures outline supervision means more than just watching the youth, it means being involved with them. There are three levels of supervision which includes active involvement, supporting supervision, and static supervision. During outdoor activities and/or movement, staff were observed to be strategically positioned to ensure proper supervision and to ensure there were no physical obstructions in their view of the youth. Observations of interactions with program staff and the youth reflected they were positive and followed the program's behavior management system. Program procedures indicated when a youth is not present for headcount and the location of the youth is unknown; the regional director, program director, director of operations, director of treatment, director of case management, shift supervisors, direct-care staff, law enforcement, Department staff, the Department's Central Communications Center (CCC), and parent/guardian will be notified. Informal interviews were conducted throughout the annual compliance review week and confirmed staff understood the procedures to take when there is a discrepancy in youth counts. Staff explained the procedures included stopping all movement, performing a recount, performing an emergency count and comparing it to the youth roster, notification of program administration and supervisory staff, securing youth, and conducting a perimeter search and a facility program search. When the count is not reconciled and a youth is missing, law enforcement is notified, and the Department's CCC is notified. During fire drills, all program youth are gathered together and are escorted by staff outside in the fenced back yard. Observations of youth movement found each youth counted off individually in the presence of staff to ensure all youth were accounted. All on-site and off-site youth and staff movement is documented in the facility's logbook which is maintained by the program shift supervisor. Youth counts are conducted and documented in the logbook to include the count on campus and the count for each activity.

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

The program maintains a written policy and procedures ensuring their behavior management system (BMS) is designed to maintain order and security, provide constructive discipline, 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. The BMS also called the AMIkids Personal Growth Model, includes a process wherein staff explain to the youth the reason for any sanction imposed prior to the end of the staff member's workday. The youth is provided an opportunity to explain their behavior in which staff and the youth discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternative acceptable behavior.

The BMS is consistent with the principles of learning theory to include a wide variety of rewards, appropriate consequences and sanctions, consequences applied immediately with certainty and matched to the severity of the behavior, and rewards outnumbering the consequences. Youth earn points daily for complying with program rules and expectations. Earned points are documented on point cards and totaled daily .At the end of the week, youth are rewarded based on the number of points earned. Tabulated points are posted in the dining area, dorm, and the director of operations' office which determine privileges for order in the food line, seconds and special desserts, reward activity for top youth, graduation eligibility for Ensign Rank holders, and length of telephone time. Youth who achieve card status and have met the ninety-day length of staff requirement are eligible to participate in off-campus reward trips and class activities. Special events such as campus trips, overnights trips, AMIkids challenge event, community services, in-school contests, and peer counseling are privileges earned with positive behavior as noted on the youth's point card. When participation is limited, the chart positions are to be the deciding factor. Five youth records were reviewed and validated each youth received orientation to the BMS to include rules governing conduct and positive/negative consequences for behaviors.

The program utilizes a token economy system providing an immediate reward for good behavior. Staff are assigned a monthly budget and they award tokens based upon the budgeted amount available for the month. The token is valued at approximately one dollar and is designed according to the principles of classical conditioning and is intended to promote short term change by training the youth to associate approval with socially desired actions. According to staff interviews, the program's BMS has not changed since the last annual compliance review. Observations made during a tour of the program and throughout the annual compliance review week supported the BMS was outlined in the youth handbook and also posted on the meeting room hallway bulletin board. The program has an annual pre-service and in-service training plan which includes the BMS for all staff. A review of five staff pre-service and five in-service training records supported each staff received the required training. The program could not provide sign-in sheets for the Escambia County School District teachers receiving the required training; however, an interview with the program director and director of operations indicated the staff did

receive the training. An interview with a teacher indicated they believed they received training on the program's BMS. The program director was interviewed and indicated the BMS consequences also include behaviors in the classroom. Supervisors are trained to monitor the use of rewards and consequences by staff. Five interviewed youth rated the program's BMS as good.

5.03 Behavior Management System Infractions and System Monitoring	Limited 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 maintains a written behavior management system (BMS) which provides for positive and negative consequences in a ratio of four-to-one positive-to-negative consequences. However, the program's contract outlines the ratio of rewards to punishments shall exceed seven-to-one. The behavior management and positive behavior reinforcement system shall focus on improving the youth's emotional and behavioral functioning, addressing and eliminating behaviors contributing to the youth's delinquency, and promoting behavior and competencies which encourage pro-social change, self-growth, and law-abiding behavior. Consequences for violation of rules are to be applied logically and consistently and are directly related in severity to the seriousness of the inappropriate behavior exhibited. Consequences and sanctions are applied individually and group punishment is never allowed. Youth are not denied basic rights to include increased length of stay, meals, clothing, sleep, physical health services, mental health services, education services, exercise, correspondence privileges, contact with parent/guardians, attorned of record, juvenile probation officer, Department of Children and Families case worker, and clergy. Youth are not permitted to punish other youth. Informal interviews with youth and staff validated this practice.

An interview with the program director indicated staff responsible for implementing the BMS include direct-care staff, shift supervisors, recreation therapist, clinical case managers, director of operations, and activities instructor. Reviewed documentation indicated the direct-care staff, shift supervisor, and the recreation therapist position descriptions included implementation of the BMS. The activities instructor, director of operations, and clinical case manager's position descriptions did not include the implementation of the program's BMS. According to staff interviews, the program does not utilize room restriction. However, an informal interview with the director of operations confirmed the program's policy for ten-minute checks reference the use of room restriction. Informal interviews with youth indicated they have not been placed on room restriction. Observations found during a tour of the program, the youth rooms do not have doors attached. A review of the program's contractual agreement found all required parties were involved in the development, implementation, and on-going maintenance of the BMS. The contract also indicates the provider shall implement its AMIkids Targeted Behavioral Interventions system as part of the AMIkids Personal Growth Model, which is based on a structured and integrated level system, utilizing a rank/phase system, point card, and token economy system. A review of five pre-service training records and five in-service training

records revealed each staff has received training for the program's BMS. Five staff were interviewed and indicated youth are informed of consequences by having a conversation with the youth and provide them with other ways they could have handled the situation. Youth are provided a chance to explain their behavior. Two youth indicated they are informed at the end of the day when points are awarded. All five staff indicated they received feedback from supervisors regarding their implementation of the BMS on a one-on-one basis and during staff meetings. Five youth were interviewed and rated the program's BMS as good.

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 maintains a written policy and procedures ensuring 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. All ten-minute checks shall be documented with a written document such as a head count sheet, a facility log, or with a method of electronic documentation. Documentation shall include the actual time of each check and the initials of the staff conducting the check in the case of paper checks sheets or a method of determining the staff conducting the checks if checks are documented electronically.

The program has a video surveillance system consisting of fifteen total cameras, all of which were reported and were observed to be operational. The cameras are strategically located throughout the program. The camera monitoring system is able to store video recordings up to seventeen days. Florida Administrative Code requires the program to have a minimum of thirty days. The program reported the previous digital video recording (DVR) system had a forty-five day recording storage; however, it became disabled on October 16, 2019 and was reported to the Department's Central Communications Center (CCC). Upon departure on the last date of the annual compliance review, the program produced an email which documented the DVR as having the capabilities to store recordings up to thirty-five days. During the annual compliance review period, the program had one reported incident to the Department's CCC whereby on December 12, 2019 during a video review, the program manager discovered a direct-care staff falsified the ten-minute check log on December 1, 2019. The staff member received a written reprimand in addition to retraining. Observations of six separate days for the duration of an hour, one B-shift and five C-shift, found all ten-minute checks were conducted as required with the exception of one being one minute late.

Reviewed documentation of the program's ten-minute check logs reflected staff documented the actual time of the room check and initialed on the ten-minute check log sheets verifying who completed the room check. Five interviewed staff each confirmed room checks are conducted every ten minutes when a youth is placed in their room for sleeping or non-punishment reasons. The program's executive director advised a training was recently conducted with all staff on policy and procedures regarding ten-minute checks at night and during shift changes while the youth are in their beds sleeping. Five interviewed staff indicated room checks are conducted every ten minutes when a youth is placed in their room. Three staff also indicate the times are between seven and ten-minute intervals.

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

The program maintains a written policy and procedures ensuring 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. 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 it is practicable after order has been restored.

Observations found the program maintained a chronological record of events, incidents, and activities in a daily shift logbook. Youth were accounted for by a physical count and through random head counts throughout each day when youth moved from one activity to the next. Observations made during the annual compliance review week supported youth were queued and each counted prior to movement. Staff documented the count in the daily shift logbook. Observations of counts conducted were in the classroom, dormitory, and outdoor activities. The daily census is documented in the daily shift logbook by the shift supervisor.

A review of randomly selected dates and times in the daily shift logbooks for the past six months was conducted and reflected youth counts were completed at the beginning of each shift, after outdoor activities, and after movements from one area of the program to another. The counts were not documented after conducting drills when exiting the building. All formal and informal counts in the logbook include the time of the count, location, and number of accounted youth. In addition, the program completes a Resident Log when a youth exits the program for off-site activities. The log includes the youth name, date, destination, staff providing transportation, and the time in and out of the program. Five staff were interviewed and each was aware of the program's policy and procedures on adequate supervision of youth as well as procedures if there are discrepancies in youth counts, including emergency counts.

In the event of a discrepancy, staff reported all movement is stopped and a recount is conducted. Everyone comes out to the middle room and two or three people conduct a count. If the count remains out of compliance, administration would be notified and the Department's Central Communications Center (CCC) would be contacted.

5.06 Logbook Entries and Shift Report Review	Failed 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 written policy and procedures ensuring the maintenance of a chronological record of events, incidents, and activities in a central logbook. The program ensures direct-care staff including each supervisor, are briefed when coming on duty. The program maintains two spiral-bound logbooks with numbered pages for each month, one for the first half and the other for the second half of the month.

Observations and review of logbooks for the previous six months found logbook entries were documented in ink with no erasures or white-out areas. Errors were not struck through with a single line, dated, and initialed by the person correcting the error. Observations found the errors were either scribbled out or written over top. Reviewed documentation of randomly selected days within the logbooks reflected each entry did include the date and time of the event with the name of the staff and youth involved. A brief description was also documented. Reviewed logbooks did not consistently support the oncoming direct-care staff and shift supervisor documented a review of the logbooks prior to the start of their shift. Although there was a pre-printed line for the program director to document their review, there was no documented practice found. Reviewed shift logbooks did not consistently document the shift supervisor counts and/or signatures. Emergency counts were not consistently documented nor were any special instructions for supervision and monitoring of youth documented.

Perimeter checks were pre-printed with start of shift and end of shift with staff circling “yes” or “no”. Observed practice found “yes” was circled for each reviewed daily shift logbook; however, there was no space or documented practice of what was checked and/or observed and if there was anything compromised or contraband found. Admission and releases were documented; however, did not include the time of anticipated arrival or departure, and mode of transportation. Reviewed logbooks did not support internal incidents reported to Florida Abuse Hotline and/or the Department’s Central Communications Center (CCC) were consistently documented.

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

The program has a written policy and procedures for key control and security which includes assignment, inventory, tracking, and the storage of keys. The system includes key assignment including restrictions on usage, inventory and tracking of keys, secure storage, and procedures for missing and/or damaged keys. Observations made throughout the annual compliance review week found staff turned their personal keys in the combination locked box located in the computer server room in administration.

All staff, regardless of receiving permanent or temporary shift keys are responsible for placing their personal keys into the secured key box. According to program's procedures, the master key control box is located in the business manager's office. The business manager and maintenance manager are responsible for the control, issuance, and return of all keys. The maintenance manager is responsible for issuance, inventory, and status of all keys. All key rings are required to be tagged to record the ring number, keys assigned, and number of keys on the ring. All key rings and keys were recorded on the Key Ring Reference Log. A random review of three staff and their assigned keys did not match the Key Ring Reference Log. An additional review of three staff and their assigned keys was conducted and only one matched the key log. An interview with the director of operations and direct-care staff indicated direct-care staff are not assigned keys by checking them out, rather through an honor system of collecting the keys from the outgoing staff. This practice was not consistently documented in the shift logbook.

An interview with the director of operations and maintenance manager indicated damaged keys are replaced through Morris Lockmand Safe in Pensacola, Florida. The maintenance manager takes the broken key and the locksmith makes a new key and keeps the broken one. Observations made during a tour of the program found there is an extra key box located in the director of operations office with old keys which were not inventoried. Staff were informally interviewed at random throughout the week of the annual compliance review and confirmed none had their personal keys in their possession. Five interviewed staff found each was knowledgeable of the key control process including interviewed staff each were knowledgeable of the key control process including how keys are assigned and the process for missing or lost keys, damaged keys, and restricted keys.

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

The program has a written policy and procedures ensuring the program delineates items and materials considered contraband when found in the possession of youth. The program has a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, grounds, staff, and youth. The program defines items and materials considered contraband when found in the possession of youth. The program provides youth with a list of contraband and informs each youth of the consequences if found with contraband. At the discretion of the director of operations, contraband or other material

which is not illegal is either discarded, returned to the original owner, mailed to the youth's home, or stored and returned to the youth upon release.

Observations made during the annual compliance review week supported the director of operations maintains a box of contraband separately placed in grey-colored bags with the youth name and item on the room search form accompanied with the direct-care staff and shift supervisor's signatures. Review of the documented practice did not support the documentation was maintained in the youth case management record. Each youth is provided with youth handbook and orientation information upon admission into the program. The information outlines program rules and list items considered to be contraband. A review of the list of items considered to be contraband included personal cellular telephones and/or equipment or electronic devices capable of taking pictures or video recordings, which are prohibited. However, the youth handbook or policy did not include all items considered contraband as outlined in Florida Administrative Code nor did it outline how youth are informed of consequences if found with contraband. The program's policy indicates facility searches will be conducted at least once a week and will consist of an inspection of the physical plant and property, including youth sleeping quarters. These searches will be documented in the shift reports and on the Contraband Seizure Log identifying the disposition of the confiscated item. Youth are searched upon returning from a supervised off-campus activity away from the program, from participating in vocational or work programs involving the use of tools, or other implements which could be used as weapons.

Observations made throughout the annual compliance review week supported youth were searched and patted down when transported off-site and upon return. The program's policy outlined incoming mail for youth is searched in the presence of the youth; however, the policy did not identify searching outgoing mail. Interviews with the director of operations and direct-care staff indicated the outgoing mail is searched; however, there was no documentation to support the practice. Periodic unannounced searches of youth common areas are conducted as often as necessary to control contraband. The shift supervisor is responsible for conducting an inspection of a youth's locker and/or assigned personal space daily to ensure the area is neat and does not contain contraband. Direct-care staff are responsible for conducting searches in the classrooms and common areas. The director of operations is responsible for conducting unannounced inspections of the program every quarter or more often if contraband is found. The search is documented on the Security Checklist. The program's policy and procedures did not address any staff, including supervisors and administrators, who are found in possession of contraband will be subject to disciplinary action up to and including dismissal. In all instances involving confiscation of illegal contraband, the program shall turn the item over to the local law enforcement and a criminal report will be filed. The policy did not include the contraband guidelines of what is considered illegal.

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

The program maintains a written policy and procedures to ensure searches and full body visual searches are conducted in accordance with Florida Administrative Code. Youth are searched upon their admission to the program, before and after off-campus activities, outdoor activities, visitation, school, group, outdoor recreation, meals, and vocational or work projects involving the use of tools. Youth who are a new admission, re-admission, returning from visitation, returning from off-campus, suspected of contraband, or are a security risk receive a full body visual

search and are required to sign a search form indicating the search procedure was explained. Reviewed documentation confirmed searches occurred after these activities.
Searches of the youth are conducted by two staff members with one being the same gender as the youth and the search is conducted in a private area. Full body visual searches are conducted in a private room with two staff members present, both of the same gender as the youth being searched.

As an alternative, when two staff of the same gender are not available, the search can be conducted by one staff of the same gender, while the staff of the opposite gender is positioned to observe the staff member conducting the search; however, cannot view the youth. Parent/guardians are notified of searches during visitation by way of a parent intake letter. This letter is sent to the parent/guardian at the time of the youth's admission. Observations of searches were conducted throughout the week of the annual compliance review of youth transported off-site and return, from classroom to classroom, after school, youth walking to mess hall, and after daily outdoor activities. Youth were given instructions regarding the search and were searched by a staff member of the same gender. Searches were conducted in a manner not to degrade the youth and were based on the Protective Action Response training manual. Five interviewed staff each confirmed the process for conducting searches and stated youth are searched after every movement or any time a count is conducted or staff lose sight of the youth. Five interviewed youth each indicated searches occur when returning from off campus and after outdoor recreation. Two youth indicated after meals.

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

The program maintains a written policy and procedures in place ensuring any vehicle used to transport youth is properly maintained and contains safety and emergency equipment, in order to be operated in a safe manner. Each vehicle utilized 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. The program's maintenance manager maintains an inventory of all program vehicles with vehicle preventative maintenance documentation and annual inspection documentation. At the time of the annual compliance review, the inventory listed six separate vehicles; however, the program indicated they had three vehicles. The program was able to produce documentation to support one vehicle was surplussed and removed on April 22, 2019. One other vehicle was surplussed and removed on January 21, 2020. The program had a rental and returned it on October 25, 2019. Reviewed documentation and invoices supported each of the three program vehicles received an annual safety inspection in January 2020. There were no recommendations for repairs. The remaining three vehicles, no longer on-site, also received annual inspections within the last twelve months. Each vehicle was observed and was equipped with an up-to-date fire extinguisher, seatbelt cutter, window punch, and the appropriate number of seat belts. In addition, each vehicle was fitted with a club steering locking device.

Staff interviews indicated the driver can manually enable the child safety locks ensuring the doors cannot be opened from the inside while traveling. Each vehicle is assigned to a first aid kit which is maintained and housed in the computer server room in administration. Observations made during the annual compliance review week found only one first aid kit in the computer server room. Interviews with the director of operations indicated the remaining two were with the medical staff for inspection and replenishing. Observations of the daily inspection of the vehicles supported each vehicle receives an inspection prior to utilizing and the practice is documented on the Vehicle Maintenance Checklist.

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

The program maintains a written policy and procedures ensuring compliance with the appropriate minimum staff-to-youth staffing patterns are maintained while youth are transported off-site to ensure the safety and security of youth, staff, and the public. The program has three vehicles utilized to transport youth. Observations of a transport off-site and a return supported youth and staff wore seat belts while the vehicle was in motion. Informal interviews with transportation staff confirmed youth are never attached to any part of the vehicle by any means other than proper use of a seat belt. Both youth and staff wear seatbelts during transportation. Prior to departure, each youth removed their shoes, lifted their legs so staff could see the bottom of their feet, and received a pat-down. One male staff member stayed with the youth outside of the vehicle while the female staff member inspected the vehicle inside and out before youth were allowed to enter. Informal interviews with the director of operations indicated a cellular telephone is issued for transports when direct-care staff are transporting. Youth. Administration maintains program-issued cellular telephones and will utilize them when participating in a transport. Both transports indicated the staff-to-youth ratios were two staff and five youth for each transport. A random check of five personal vehicles and all three program vehicles ensured they were locked when not in use. A review of five personnel records for staff authorized to provide transportation, found all had a current Florida driver's license. An informal interview with the program's human resources staff supported all new hires are checked for a valid driver license. Five interviewed staff indicated they are not allowed to use personal vehicles to transport youth.

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

The program has a written policy and procedures ensuring a safe and secure physical plant, grounds, and perimeter shall be maintained while conducting weekly safety and security audits. The program's director of operations is responsible for conducting weekly safety and security audits and submitting the audits to the Department. Identified deficiencies were documented on these reports; however, there was no clear follow-up as to how the deficiency was rectified. The program did not have a clear internal system to verify the deficiencies were corrected and existing systems are improved, or new systems are instituted as needed to maintain compliance. However, based on the reports, the deficiencies were corrected as they were not identified on subsequent reports. The program could not provide evidence the weekly safety and security audits were completed every seven days. A sample from each month was provided to the review team. Each reviewed audit indicated the digital video recording (DVR) device was verified to ensure it maintains recordings for at least thirty days or longer. The program's DVR

maintains a maximum of seventeen days of recordings. An informal interview with the program administrator indicated the process in identifying and tracking safety and security deficiencies is through the weekly safety and security audits.

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

The program maintains a written policy and procedures ensuring youth do not utilize tools or equipment as weapons or security breaches. Tools shall be marked or identified and shall be securely stored when not in use and inventoried at least monthly. Tools with sharp edges or points and have a high potential to be used as a weapon, are inventoried daily except on days when they are not in use. The maintenance manager is responsible for conducting the inventories and securely maintaining all tools and equipment. The maintenance manager completes a Maintenance Daily Task Sheet, which documents checks each day of items such as tool inventory, checks of fire extinguishers and thermostats, chemical inventories, and facility sinks and toilets. All maintenance tools were inaccessible to youth and were observed to be secured in the maintenance office and outside garage shop. All tools are inventoried daily by the maintenance manager.

Observation of the daily inventory was conducted. Tools were primarily stored utilizing a shadow-board system and were marked for easy identification. There were some tools securely stored in the maintenance manager's office; however, they were inventoried as required. The maintenance manager maintained a maintenance bag, which contained a variety of tools used to complete projects within the secure area. The bag is inventoried daily and signed-in and out utilizing a tool log. An interview with the maintenance manager indicated the items in the tool bag were the only items permitted to enter the secure area. Class B tools such as mops, brooms, and buckets are maintained in the patio storage, which is accessible by all direct-care staff keys. The items are utilized by staff and youth when performing daily cleanup activities. Staff are required to sign-in and sign-out log when items leave and return to the storage area. All outside water is inoperable. According to the maintenance manager, in November 2019 the naval base employees hit a main line and the water was cut off only on the outside. The program provided ongoing communication with the naval base to have the line repaired; however, no date has been established as of the annual compliance review.

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 maintains a written policy and procedures ensuring youth use tools safely and are supervised appropriately in order to prevent injuries. The program staff-to-youth ratio during a work project is no less than one staff to five youth. Interviews with five staff indicated the program does not institute disciplinary work assignments and do not participate in vocational work activities involving on-site tool usage other than lawn maintenance safety.

Reviewed documentation supported four youth are participating in lawn maintenance safety with the maintenance manager. At the time of the annual compliance review, there were four youth participating in forklift training at Goodwill Easter Seals. Reviewed documentation supported some youth participated in the Florida Restaurant and Lodging Association SafeStaff Food

Handler Training Program. Risk assessments were completed for youth who participated in vocational or off-site activities. The director of operations was interviewed and indicated youth who participate in off-site vocational activities must meet the criteria such as age, education, maintenance of treatment and performance goals, and successfully pass the off-site risk assessment. Youth are permitted to utilize tools to clean the program. A review of five staff training records and five youth case management records indicated staff and youth are trained on the safe use of Class B tools only. Five interviewed staff indicated youth are permitted to utilize mops and brooms. One staff indicated youth can also use scrub brushes. Observations during the annual compliance review found youth utilizing brooms and mops for clean-up activities with staff providing direct supervision.

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

The program has a written policy and procedures for outside contractors entering the program areas with tools and equipment. The program restricts tools to those necessary, checks tools upon the worker's arrival and departure, restricts youth access to the work area, ensures immediate reporting of any tool the worker cannot locate, and follow up if any tool is missing. The program provides all external contractors with a Contractor Tool Inventory Verification form to complete. The form documents all tools brought in and out of the program. The maintenance manager meets with all outside contractors upon their arrival to discuss the guidelines and restrictions. Reviewed documentation supported the forms were signed by the outside contractors and witnessed by the maintenance manager. The contractor's vehicle keys are securely maintained and secured in the maintenance manager's office on an assigned key ring rack. An interview with the maintenance manager indicated they shadow the outside contractors during the entire time they are on-site. A review of project invoices submitted to the program by each vendor as well as sign-in and sign-out logs by the contractors, matched the dates indicated on the Contractor Tool Inventory Verification forms.

5.16 Fire, Safety, and Evacuation Drills	Limited 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 maintains a written Continuity of Operations Plan (COOP) which was approved by the Department on March 19, 2019 and a written policy and procedures ensuring drills must be consistent with the program's COOP. The COOP requires the program to conduct unannounced fire drills once a month for each shift. Drills are to be conducted on a random basis under varied conditions when a majority of the youth are available. The shift supervisor and program director may coordinate drills to ensure adequate staff coverage. The program is required to conduct fire drills monthly and on each shift. Reviewed documentation supported fire drills were conducted on all three shifts, as required.

The program did not conduct practice drills ensuring fire, severe weather, disturbance/riot, bomb threat, hostage situation, chemical spill, flooding, and terrorist threats/acts on a rotating basis. Reviewed documentation found the program conducted a tornado drill in June 2019 on all three shifts, a hurricane drill in September 2019 on all three shifts, flooding in December 2019 on C-shift, and power outage in December 2019 on A-shift and B-shift. Drill documentation included the type of drill, date and time, participants, brief scenario, and findings and recommendations.

The program was unable to locate the annual review of the fire extinguishers. The maintenance manager documents a monthly inspection on each fire extinguisher. The program received their annual life safety inspection from the fire marshal on September 17, 2019 and were place on a plan of corrective action for violations in the fire sprinkler system, fire alarm, and fire rated doors in need of repair/replacement.

A follow-up inspection was conducted by the fire marshal on January 29, 2020 indicated all violations were corrected with no open violations remaining. Five interviewed staff reported they have participated in a fire drill over the past twelve months. Two staff indicated they participated in an escape and weather drill. One staff indicated they participated in major disturbance, bomb threat, hostage situation, chemical spills, flooding, and terrorism. Three staff indicated they participated in medical drills. All five interviewed youth responded they participate in fire drills and have been instructed on what to do in the event of a fire.

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

The program maintains a Department approved Disaster and Continuity of Operations Plan (COOP) available for all staff to review. The program director and director of operations were interviewed and indicated the COOP is available to all staff and is located in the program director's office, director of operations office, and in the copy room. The plan was approved by the Department on March 19, 2019 and provides for basic care and custody of youth in the event of an emergency or disaster. The COOP addresses phases of a disaster plan as well as emergency management including preparedness, response, and recovery. The COOP also addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. A review of the plan indicated alternative housing has been identified should the program have to be evacuated due to an emergency or disaster. Reviewed documentation confirmed the program maintains critical identifying information in a hardcopy binder for case management, mental health and substance abuse, and a separate binder for medical. All binders are easily accessible and mobile in the event of an emergency situation resulting in the program relocating quickly or in the event needed information cannot be accessed electronically for all youth in the program. A review of five binders found each contained all required elements. The program did not provide the annual compliance team evidence of maintaining a supply of provisions and equipment required for continuous operation of services.

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 maintains a written policy and procedures ensuring strict control of flammable, poisonous, and toxic items and materials and a complete inventory of all such items. Observations found all materials were maintained in a separate secured block building located inside the fenced yard, inaccessible to youth. Inventories were maintained daily by the maintenance manager. An interview with the maintenance manager indicated gasoline is not maintained on-site and is purchased on the day the lawn is to be mowed. Safety Data Sheets (SDS) for all items were maintained. The maintenance manager, program director, and director of operations are the only staff with access to the bulk storage and flammable storage areas. The patio storage area is accessible by all staff to include the direct-care staff and is located where cleaning supplies and laundry detergent are stored for use in the program. Observations supported there were SDS for all stored items.

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

The program maintains a written policy and procedures ensuring youth shall not be permitted to use, handle, or clean-up dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's bio-hazardous material, bodily fluids, or human waste. The program maintains control of these items through storage outside of the secure area. The storage closets and cabinets were observed to be locked inaccessible to youth. During the annual compliance review, no youth were observed using or handling any chemicals or toxic materials during daily clean-up activities. Four of the five interviewed youth reported they use window or toilet cleaner. One youth indicated they use paint for art projects. Each of the four youth indicated staff spray and the youth wipes the cleaning products.

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

The program maintains a written policy and procedures for the disposal of all flammable, toxic, caustic, and poisonous items. The maintenance manager or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or sold waste shall be responsible for the disposal of these materials. The maintenance manager was interviewed and reported disposal is conducted as outlined on the Safety Data Sheets (SDS). In the event toxic chemicals or materials are needed to be disposed of, will be according to the SDS as well as through notification of the fire marshal and naval base personnel.

An interview with the maintenance manager indicated disposal procedures utilized are the Department of Navy protocols and are in accordance with the Occupational Safety and health Administration (OSHA) standards. The maintenance manager indicated there were no documented practice since the last annual compliance review of disposal of chemicals. An interview with the program's registered nurse (RN) indicated bio-hazardous waste is disposed of in a container marked as 'bio-hazardous waste material' and was observed located in the medical clinic. The RN stated the program maintains a contract with Stericycle who will come to the program to pick up any waste and dispose of it properly. There was no reported incident of any disposal needed for bio-hazardous waste during the scope of the annual compliance review. All hazardous liquids, gasoline, chemicals, and cleaning agents are stored and secured which are inaccessible to youth. The program does not prepare meals on-site; therefore, there were no applicable kitchen liquid waste or grease containers. An interview with director of operations and the maintenance manager indicated all cleaning waste such as dirty mop water is disposed of in mop sinks and drains. In the event of a chemical spill, the material would be cleaned according to the SDS.

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

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

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

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

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

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

The program maintains a written policy and procedures ensuring proper supervision and safety of the youth during water-related activities. The procedures also ensure staff are appropriately trained for each specific type of water activity. Reviewed documentation and interviews with program staff indicated the last water-related activity was conducted in June 2019. The certified level two lifeguard resigned from the program and the program has not been able to obtain another certified lifeguard. Two youth participated in the aquatic trip to the University of West Florida swimming pool to be swim tested. Prior to participating, each youth received a risk classification and the parent/guardian was notified. Safety rules were explained to the youth. Rescue and safety equipment inventory was conducted. Five interviewed youth indicated they do not participate water activities.

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures ensuring youth are provided the opportunity to receive visitation and communication opportunities. Upon admission, each youth is oriented and provided with the program's visitation policy and guidelines. The program's visitation policy indicated consideration for requests of alternative visitation arrangements with parent/guardians,

if needed. According to policy, visitation for all youth will occur every other Sunday from 10:00 a.m. to 2:00 p.m. Attorneys, juvenile probation officers, and clergy may visit with the youth after scheduling a time with the director of operations or case manager. Five reviewed youth case management records documented each youth signed for receiving information concerning visitation, telephone, and mail procedures upon admission. The program posted their visitation schedule and rules throughout program areas.

Interview with program staff indicated the program encourages visitation and communication between youth and their family. Case management records were reviewed and included evidence of a telephone and mail log and schedule. Each youth receives a youth handbook which outlines youth rights and includes their right to visitation, telephone, and mail access. Five interviewed youth each reported receiving opportunities to communicate with their family members by mail, telephone, or during visitation.

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

The program does not utilize controlled observation; therefore, this indicator will be rated non-applicable.

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

The program does not utilize controlled observation; therefore, this indicator will be rated non-applicable.

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

The program does not utilize controlled observation; therefore, this indicator will be rated non-applicable.

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

The program maintains a written policy and procedures ensuring a safety plan is maintained for each youth in a centralized location for all staff. A review of five youth case management records and five youth safety plans found the plans were not completed within fourteen days of admission. Reviewed practice indicated the safety plans were not completed until January and February 2020. Two youth were admitted to the program in July, two youth admitted in September, and one youth admitted in November 2019. Each reviewed safety plan did include

warning signs identified by the youth when the youth is escalating in their behavior. It was not clear how the parent/guardian, family member, collateral contacts, or treatment team members were included in the discussion and development of the safety plan. There was no evidence of incorporating any recommendations from previous or current clinical assessments, screening instruments, or trauma responsive practices. The program had no documented practice of updating each plan every thirty days or following any significant behavioral or mental health event identified by the youth intervention and treatment team. The program maintains a binder with the safety plans located in the designated mental health clinician authority's (DMHCA) office. An interview with the DMHCA indicated staff have access to the office. Three of five interviewed staff indicated the safety plans were located in the DMHCA's office. One staff indicated the case manager's office and one staff indicated in the back hallway by the exit doors. Five interviewed staff found none reviewed the safety plans. One indicated if something happens, they will notify their supervisor. Another staff indicated they have been shown the plans and one indicated they are in binders in the back. Five interviewed youth indicated they were involved in the development of their safety plan.