STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Escambia Boys Base

AMIKids, Inc.

(Contract Provider)

Building 3780 Corry Station

Pensacola, Florida 32511

Review Date(s): January 29 - February 1, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Patrick M McKinstry, Office of Program Accountability, Lead Reviewer (Standard 1)
Jessica Gibson, Office of Programming and Technical Assistance, Technical Assistance Specialist (Standardized Primary Evidence-Based Programming) (Standard 2)
Katrina Harper, Probation, Juvenile Probation Officer Supervisor (Interviews)
Lea Herring, Office of Program Accountability, Regional Monitor (Standard 3)
Donald Lasseter, Twin Oaks Development, Inc., Program Director (Standard 4)
Ken Phillips, Office of Program Accountability, Regional Monitor (Standard 5)

Program Name: Escambia Boys Base
Provider Name: AMIKids, Inc.
Location: Escambia County / Circuit 1
Review Date(s): January 29 - February 1, 2019

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

Methodology

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

Persons Interviewed

☒ Program Director
☐ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
1 # Case Managers

2 # Clinical Staff
NA # Food Service Personnel
2 # Healthcare Staff
1 # Maintenance Personnel
1 # Program Supervisors

5 # Staff
5 # Youth
NA # Other (listed by title): _____

Documents Reviewed

☒ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☐ Confinement Reports
☒ Continuity of Operation Plan
☒ Contract Monitoring Reports
☒ Contract Scope of Services
☒ Egress Plans
☐ Escape Notification/Logs
☒ Exposure Control Plan
☒ Fire Drill Log
☒ Fire Inspection Report

☒ Fire Prevention Plan
☒ Grievance Process/Records
☒ Key Control Log
☒ Logbooks
☒ Medical and Mental Health Alerts
☒ PAR Reports
☒ Precautionary Observation Logs
☒ Program Schedules
☒ Sick Call Logs
☒ Supplemental Contracts
☒ Table of Organization
☒ Telephone Logs

☒ Vehicle Inspection Reports
☒ Visitation Logs
☒ Youth Handbook
5 # Health Records
5 # MH/SA Records
18 # Personnel Records
10 # Training Records/CORE
3 # Youth Records (Closed)
5 # Youth Records (Open)
JJIS # Other: _____

Observations During Review

☒ Admissions
☐ Confinement
☒ Facility and Grounds
☒ First Aid Kit(s)
☒ Group
☐ Meals
☒ Medical Clinic
☒ Medication Administration

☒ Posting of Abuse Hotline
☒ Program Activities
☒ Recreation
☒ Searches
☒ Security Video Tapes
☐ Sick Call
☒ Social Skill Modeling by Staff
☒ Staff Interactions with Youth

☒ Staff Supervision of Youth
☒ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☐ Transition/Exit Conferences
☒ Treatment Team Meetings
☐ Use of Mechanical Restraints
☒ Youth Movement and Counts

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

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 the following services: mental health overlay services (MHOS). In addition, the program fosters each youth by providing, Aggression Replacement Therapy (ART), Cannabis Youth Treatment (CYT), 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. Program administration is comprised of a program director, program manager, operations manager, director of treatment, and a business manager. Case management services are provided by two case managers. Mental health staff at the program includes one director of treatment, two therapists, and a contracted psychiatrist. Medical services are offered 7:00 a.m. to 7:00 p.m. and are provided by five registered nurses and one contracted designated health authority (DHA). Educational services are provided by the Escambia County School Board. 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 for on base at a separate location. The program has fifteen operating security cameras providing coverage. At the time of the annual compliance review, the program had four vacant positions; one recreational therapist, one case manager, and two direct care staff.

Strengths and Innovative Approaches

- Youth are able to receive a certification in cardiopulmonary resuscitation (CPR) and first aid.
- Youth are able to receive a nationally recognized forklift certification, which is good for three years.
- Youth are given with the opportunity to complete Keys To Success, a program developed to engage young minds towards their future potential, providing ten hours of hands on experience designing a business website. Equipment and instruction were funded through a grant from a local business.

Standard 1: Management Accountability

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

A total of sixteen staff records were relevant for initial background screening. Each of the staff records reviewed found a background screening was completed prior to the staff's hire or becoming a volunteer. In addition, a criminal history report was reviewed. None of the sixteen staff records reviewed required an exemption prior to working with youth. There was no indication of staff having had a break in service, as indicated within the Staff Verification System (SVS). All sixteen-staff reviewed had a pre-employment assessment tool administered. The program utilizes the Diana Screening instrument as their pre-employment assessment tool. Each of the staff were in receipt of a passing score, which was clearly documented in their employment records reviewed. The program added each employee/volunteer to the Background Screening Unit (BSU)/Clearinghouse employment roster. The program assesses each potential candidate before allowing access to the program, by reviewing the Central Communications Center (CCC) person involvement history report, SVS module, and Florida Department of Law Enforcement (FDLE) Automated Training Management System results. There was no need for a background screening to be completed for a Department employee having been hired by the provider or when a provider employee is hired by another contracted provider. The program background screens any person who assist or interacts with youth on an intermittent basis for less than ten hours and may have access to confidential information. An Annual Affidavit of Compliance with Level 2 Screening Standards, was completed and sent to the Department's BSU on January 10, 2019. Teachers who are paid by the school board, or funding provided by the school board or Department of Education, received an annual screening, which was completed on January 30, 2019. The Escambia Boys Base program and the school board of Escambia County, have a cooperative agreement, effective from July 1, 2018, through June 30, 2019. The agreement outlines a commitment from both the program and school board to provide a comprehensive system of care which meets the health, education, mental health, and social welfare needs of the youth served.

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

The program has a written facility operating procedure (FOP), which addresses practices for five-year rescreening. Review of the program's employee roster was conducted to determine if

there were any staff requiring a five-year background rescreening. A total of three staff were found in need of a five-year background rescreening. Each rescreening was conducted every five years, which was calculated from the staff members agency hire date. Each of the three-background rescreening's were submitted to the Department's Background Screening Unit/Clearing House at least ten business days prior to the staff member's 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.

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

On-site observations made during the annual compliance review found postings of numbers for the Florida Abuse Hotline and Department's Central Communications Center (CCC) for youth eighteen years of age and older. The program had a total of nineteen CCC calls since the last annual compliance review. Four of the nineteen were related to physical, psychological, or emotional abuse. None of the four incidents reviewed were found with any substantiated findings related to physical, psychological, or emotional abuse. A total of sixteen staff personnel records were reviewed for adherence to the code of conduct. All sixteen of the staff personnel records had a signed code of conduct.

The program has a written facility operating procedure (FOP), which addresses incident reporting requirements and child abuse reporting procedures. Guidelines within the FOP states the purpose to ensure the expeditious reporting of any incident, by any person, to the proper authorities. All allegations of child abuse or suspected child abuse must be immediately reported first to the Florida Abuse Hotline and second to the Department of Juvenile Justice CCC hotline. Youth will have unimpeded access to self-report alleged abuse. Direct care staff shall model pro-social behaviors for youth throughout the course of each day in the program, reinforce delinquency interventions, and guide and or re-direct youth toward pro-social behaviors and positive choices. The procedures for abuse reporting is as follows: A report must be made immediately. Notification is required by the person having first-hand knowledge of the incident. The report is made to the Florida Abuse Hotline, at its toll-free number. The report should answer: who, what, when, where, why, and how. The supervisor on duty will escort the youth to a phone, which will provide for a reasonable area of privacy away from other youth. The supervisor will assist the youth in placing the call to the appropriate agency. The supervisor

will speak to the contact agency to ensure proper identifying information is provided, for example; program phone number, location, and directions to the program. Once the call has been made to the proper authorities, the supervisor will contact the parent/guardian, and the program director. Notation of the alleged incident will also be documented in the program logbook including those involved, location, and time. The program director will initiate and document applicable corrective action.

Interviews with five youth were conducted. All youth stated they felt safe in the program and they have never been stopped from reporting abuse to the Florida Abuse Hotline or CCC (if eighteen or older) since they have been at the program. All youth stated staff are respectful when talking with them or other youth. Four out of five youth said they have never heard staff use curse words when speaking with them or other youth. The one youth reported they heard staff once use profanity; the youth stated, once another youth was verbally disrespectful toward staff and the staff repeated what the youth said.

Interviews with five staff were conducted. Each staff was asked to explain the process for allowing staff and youth to call the Florida Abuse Hotline or CCC to report suspected abuse. All staff were able to summarize the process. Each staff interviewed, denied ever observing a co-worker tell a youth they could not contact the Florida Abuse Hotline. Four of the five staff interviewed denied having ever observed a co-worker using profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth. The one staff who had replied yes, indicated a youth was argumentative with a staff member and the staff told the youth to shut up. Review team members followed up with this remark made from staff and noted the staff member making the comments was reminded by other staff during the incident, to not address youth in such a way.

An interview with the program director was conducted regarding the program's employee code of conduct and what actions are taken if physical abuse, threats, or profanity towards the youth is used. The program director confirmed no verbal, emotional or physical abuse is allowed. Physical abuse, threats, profanity, etc., result in actions from counseling to dismissal. The program director was asked to explain the program's incident reporting process. He stated, incidents which are "required reporting" are done so to the CCC within a two-hour period from time of incident. Telephone numbers to the CCC and Florida Abuse Hotline are posted throughout the building. Youth eighteen and older are allowed to call CCC.

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 nineteen Central Communication Center (CCC) calls since the last annual compliance review. Four of the nineteen were related to physical, psychological, or emotional abuse. The program provided their internal investigations into each of the four incidents reviewed. The documentation provided supports the efforts by management to take immediate action to address all incidents related to physical, psychological, or emotional abuse. None of the four alleged incidents found any substantiated findings for physical, psychological, or emotional abuse towards youth.

An interview with the program director was conducted to determine how the program ensures staff and youth are knowledgeable on contacting the Florida Abuse Hotline/CCC, how these type of calls are tracked, and how these results are incorporated into management meetings. The program director confirmed telephone numbers are posted throughout building. Additionally, allegations of abuse are followed up with internal investigations and coordination with Department of Juvenile Justice program monitors to ensure each concern is properly addressed. Management meetings and training of staff are places where results are shared, and proper supervision practices are discussed. The program director also confirmed there have been no allegations of abuse towards youth since the last annual compliance.

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

The program had a total of nineteen Central Communications Center (CCC) calls since the last annual compliance review. A sample of five reports were reviewed. In each of the five reports, the CCC was notified within two hours of the program becoming aware of the incident. A review of the program's logbooks revealed each CCC incident was documented. There were no indications of any internal incident reports or grievances which should have been reported to the CCC. The program has had an increase in the total number of reportable incidents to the CCC since last annual compliance review. Trend data reveals CCC reports generated since the last annual compliance review increased, for a total of nineteen. There were three incidents in the month of January 2019, one was related to an incident which occurred while the annual compliance review team was on-site; falsification of ten-minute checks. The program director was asked to explain the program's incident reporting process. He stated, incidents which are "required reporting" are done so to CCC within a two-hour period from time of incident. Telephone numbers to the CCC and Florida Abuse Hotline are posted throughout the building. Youth eighteen and older are allowed to call CCC.

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

A total of five Protection Action Response (PAR) interventions were reviewed. The reviewed PAR interventions reports were completed by the end of the staff member's workday. Each of the PAR reports included statements from all staff involved. None of the PAR interventions required the use of mechanical restraints. One of the five PAR interventions resulted in an injury to a youth, which was subsequently reported to the Central Communications Center (CCC) within two hours. None of the PAR interventions resulted in allegations of abuse by the youth. A review by a PAR certified instructor or supervisory staff was completed for each of the five PAR interventions reviewed. Two of the five incidents indicated the PAR medical review was necessary; one as a result of two youth in an altercation, the other was a chipped tooth. All five PAR interventions contained a post-PAR interview with the youth, which was conducted by the program director or designee. The post-PAR interview was conducted no longer than thirty-

minutes after the PAR intervention. All five PAR intervention reports were reviewed by the program director or designee, within seventy-two hours of the reported incident. Each of the programs PAR reports and applicable attachments are placed in a central file within forty-eight hours of being signed by the program director. The program submits a monthly summary of all PAR reports to the Department by the fifteenth of each month. The programs PAR plan was approved and signed by the Department of Juvenile Justice on February 2, 2018.

A review of PAR interventions since last annual compliance review, found the program has had an increase. The program director was asked to explain why there has been an increase, he replied: In our analysis of the increase in PAR interventions over the past year, our focus has lead us to examine turnover rate. In addition, to the level of experience and staff development. While no one variable can be cited as to the root cause, company-wide we have increased training in de-escalation techniques. Each month a session along with scenarios are provided to staff in training. The goal is to reduce and ultimately eliminate the physical portion of PAR altogether in our response. The program director was asked to explain the process for monitoring PAR incidents and use of force, he replied: The program has a compliance monitor in place to track all PAR incidents and ensure reports are completed and is recorded in monthly reports to the Department and other authorities. The program's PAR rate during the annual compliance review period was 1.44, which is below the statewide residential PAR rate of 1.47.

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

A total of five staff training records were reviewed in order to verify pre-service training requirements. Each of the staff reviewed, were certified within 180 days of their respective hire dates. Each staff completed at least a minimum of 120 hours of pre-service training. Each staff completed the following pre-service training: cardio pulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and Protective Action Response (PAR) training. Staff also completed professionalism and ethics (to include standards of conduct), suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) training. The five-staff reviewed, also included evidence of completion for contract specified training in areas, restorative justice, transition planning, gender responsive services (The Council for Boys and Young Men), post-traumatic stress disorder (PTSD), and universal precautions. In addition, the program provided the following enhanced specialized training for the specific population staff are working with, mental health overlay services. All training was documented within the Department's Learning Management System (SkillPro). The SkillPro indicates all requirements for each of the staff reviewed were completed. A review of instructors at the program found each are qualified to deliver training provided. The program submitted, in writing, a list of pre-service training to the Office of Staff Development and Training, which included course names, descriptions, objectives, and training hours for any instructor-led training. The pre-service training plan was submitted, December 27, 2018.

1.08 In-Service Training	Satisfactory Compliance

Residential staff complete twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training is completed.

Supervisory staff completes eight hours of training (as part of the twenty-four hours of annual in-service training) in the areas specified in Florida Administrative Code.

A total of five staff training records were reviewed in order to verify in-service training requirements; two supervisory and three direct care staff. Each of the five-staff received over the required twenty-four annual training hours. Each of the staff reviewed, received cardiopulmonary resuscitation (CPR) (recertification), first aid (recertification), automated external defibrillator (AED) (recertification), and refresher in Protective Action Response (PAR) training. Staff also were in receipt of training for professionalism and ethics (to include standards of conduct), and suicide prevention. The two supervisory training records reviewed, included at a minimum eight hours of additional training in areas specific to management, leadership, personal accountability, employee relations, communication skills, and or fiscal training. A review of five nursing staff training records found each have a current certification in CPR and AED training. All training for each of the staff reviewed was documented within the Department's Learning Management System (SkillPro). A review of instructors at Escambia Boys Base (EBB) document each are qualified to deliver training provided. The program submitted, in writing, a list of in-service training to the Office of Staff Development and Training, which included course names, descriptions, objectives, and training hours for any instructor-led training. The in-service training plan was submitted, December 27, 2018. The program has an annual in-service training calendar, which is updated as changes occur.

1.09 Grievance Process	Satisfactory Compliance

Program staff shall be trained on the program's youth grievance process and procedures. The program adheres to their grievance process and shall ensure it is explained to youth during orientation and grievance forms are available throughout the facility.

Completed grievances shall be maintained by the program for a minimum of twelve months.

The program has a written facility operating procedure (FOP) which addresses training requirements for the grievance process. A review of ten staff training records; five pre-service and five in-service, found evidence all ten staff received training on the program's grievance process and procedures. The program's FOP for grievances, addresses the grievance process, which includes the following phases: informal, formal, and appeal phase. A review of the FOP reveals, 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 a violation of their rights. Youth are afforded the right to grieve and be 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. They can also request grievance forms from any staff. Youth can put their completed grievance forms in any of the grievance lock boxes located in their living area, education building, or give to staff. The process for each phase as is follows: Informal Phase; the informal phase permits the youth to resolve the complaint or condition with staff on duty at the time of the occurrence of the grieved situation. The formal, is if the youth is not satisfied with the informal phase, the youth can submit a written,

signed grievance to a supervisor. The supervisor or director of operations will investigate the facts of the grievance and render a decision within seventy-two hours of receiving the grievance. If the youth agrees with the grievance, action will be taken to rectify the situation. If not, the director of operations shall forward the grievance and the supervisor's decision to the program director for review. In addition, if the formal review is conducted, all parties involved may call witnesses and introduce evidence to substantiate the decision. If the outcome is agreeable to the youth the grievance should be signed to reflect the agreement. If the youth is not in agreement with the decision of the Executive Director or designee, the youth will sign grievance to reflect such. In the third step, the appeal phase, if the youth is not in agreement with the solution offered by the supervisor, the director of operations, the program director or designee shall review and issue a decision within six days. It will be documented on the original grievance form if the youth does not agree with the solution offered in the formal/supervisor phase. All grievances are signed by a staff member and youth or the grievance indicates the youth refused to sign.

Five staff were interviewed concerning the programs youth grievance process, each staff were able to articulate the practices necessary for conducting the grievance process. Five youth were interviewed and asked about the program's grievances process, each youth identified the practice if needed to access, discuss, and complete a grievance. All five-youth agreed, they can ask for assistance in completing a grievance form. The program director was interviewed and asked to explain the program's grievance process. The program director stated: The youth attempt to resolve concerns with staff member being grieved. If youth is not satisfied with results, actions is presented to the supervisor. If the youth is still not satisfied, it is elevated to either the operations or program manager. Still further review is possible by forwarding unsatisfied grievance to the program director.

The program maintains copies of all grievances for the past twelve months; grievances were found in a three-ring notebook located with the programs "411" completed forms. The "411" sheet are request forms, youth can complete in order to speak with a particular staff. The "411" form is not to be utilized as a way to discuss a grievance, medical issue, or emergency. The program also conducts house meetings, which provide a way for youth to express concerns. The youth's concerns and staff's responses are documented and filed. The program had a total of five grievances spanning the annual compliance review period. Each of the five grievances were reviewed. All five grievances went through the informal phase and were ultimately resolved at the formal phase. Each of the grievances were responded to within the specified timeframes. During the program tour, grievances were located and accessible to youth throughout the building.

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

A review of the provider's contractual agreement found delinquency interventions included Aggression Replacement Therapy (ART), Cannabis Youth Treatment (CYT), and the Impact of Crime (IOC) curriculum. CYT and ART are evidenced-based curriculums provided at the program. The IOC curriculum is a promising practice. Five therapeutic staff, who deliver the delinquency intervention models, were reviewed for training, education level, and years working

with adult or juvenile offenders. All five-staff reviewed had received certifications for the respective delinquency interventions they delivered to youth. Each of the staff had the required education and years of experience. Education and work experience are considered by the director programing when determining staff delivery of delinquency intervention services at the program.

An interview with the program director was conducted, he was asked to explain how a staff member's education and work experience were considered when determining which staff would deliver life skills training or groups. The program director replied, staff are first hired on to specific authorized positions which requires appropriate levels of educations, training, and experience (i.e. master level counselors), specific for the purpose of conducting groups and others are selected based their education and work experience along a demonstrated desire and ability to deliver training in a group setting. The program director was also asked to explain how youth are matched to staff, counselors, and case managers and intervention groups. He replied, all youth are pre-staffed prior to arrival at the program. Based information contained in youth's records and assessments of current needs and risk factors the best suited staff are briefed on specific alert issued and any special motivational interviewing and de-escalation step recommended. The program director was asked to identify what delinquency intervention model or strategy is an evidence-based, promising practice, or a practice with demonstrated effectiveness which has been implemented to address priority needs of youth at the program. The program director replied, AMIkids personal growth model (PGM).

A review of the program's activity schedule determined the program is providing structured, planned programming or activities at least sixty-percent of the youths' awake hours. A review of group sign-in sheets was conducted to determine the groups were being delivered as designed. This was also discussed and verified with the person completing the review for standardized program evaluation protocol (SPEP); youth participating in delinquency intervention groups at the program. A review of ten staff training records was conducted; five pre-service and five in-service records. All ten staff training records contained training on the evidence-based strategies provided for at the program.

Five youth case management / mental health records were reviewed for delivery of delinquency interventions. All five-youth had evidence where they were involved in a delinquency intervention. The delinquency intervention addressed an identified priority need, which was contained within their performance plan. One youth was involved in ART, however, due to lack of participation the youth was removed. According to the case manager, the youth will be placed in a new group.

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

The youth within the program 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 offers Aggression Replacement Therapy (ART), Cannabis Youth Treatment (CYT), The Council for Boys and Young Men, and mentoring programs to provide youth with those skills mentioned. All youth receive an assessment of life skills 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 on their individualized need and according to their treatment plan. Special topic groups occur at least one time weekly and cover life and social skill topics related to the need in each youth's individualized treatment plan. Topics include, but are not limited to: behavior modification, decision making, forgiveness, positive thinking, relapse prevention, support systems, problem solving, hygiene, personal power, communication, and empathy. All life skill groups will complete a sign-in sheet at every meeting. The program has a facility operating procedure (FOP) which addresses how the services are provided. A review of the program's activity schedule demonstrates the youth are scheduled to receive life skills education, training, and or groups regularly. A review of group sign-in sheets was conducted to determine if life skills groups were being delivered as designed and confirmed youth are participating in life skills groups at the program. A review of five staff training records was conducted. Each of the staff had documentation to support they have been trained to deliver the curriculum for specified life skills training.

Five youth were interviewed and asked what groups and or activities have you participated in while at the program and what do you do in your groups. Each of the five youth were able to provide what groups they have been participating in while at the program. Some of the responses pertaining to what they do in the groups ranged from, role playing, recite skills, control anger, walk away from conflict, coping skills, deescalate techniques, and team building. Each youth was able to give an example of how they have practiced some of their skills while in and out of group.

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

The program provides Impact of Crime (IOC) groups which assist youth to accept responsibility for harm they have caused by their past actions. The IOC curriculum teaches youth about the impact of crime on victims, their families, and communities. The youth are exposed to the victim perspectives through victim speakers, in person, on video tape, or through victim impact statements. Exposing the youth to these interventions, allows youth to process reactions to each victim's account of how crime affected his or her life. The IOC curriculum provides opportunities for youth to plan and participate in restitution activities intended to restore victims and communities. Training records for staff conducting IOC curriculum were reviewed and each was certified to facilitate training. A review of the program's activity schedule demonstrates the youth are scheduled to receive IOC groups. An IOC group was observed and the group was being conducted as designed. In addition, a review of group sign-in sheets was conducted to determine if IOC groups were being delivered and confirmed youth are participating in IOC groups at the program. Five youth case management records were reviewed for delivery of IOC groups. All five-youth had evidence where they received services to increase accountability for criminal actions and harm to others.

An interview with the program director was conducted, he was asked to explain what types of restorative justice awareness groups or activities are provided for youth. The program has many long time and on-going partnerships which assist with restorative justice awareness. The program partners with both the Pensacola Police Department and the Escambia County Sheriff Office. The program also partners with United Way, Habitat for Humanity, High School High Tech, and Children Homes Society. Through these mentioned partners, the youth have

opportunities to attend workshops, meetings, conferences, presentations, as well as participate in community service work off-site.

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

A review of the program's contractual agreement, revealed the program provides The Council for Boys and Young Men curriculum for gender-specific programming. The Council for Boys and Young Men curriculum addresses the needs of the targeted gender group and basis the services on the common characteristics of its primary target population. The program's activity schedule provides for delivery of this curriculum, at a minimum of two times a week, according to the group sign-in sheets. Sessions last approximately one and half hours. The Council for Boys and Young Men curriculum is facilitated by a master's-level therapist. The Council for Boys and Young Men curriculum is a structured support group for male youth ages nine to eighteen, which follows a strength-based approach to promote healthy masculinity. The curriculum challenges myths about how to be a real man, increases emotional, social, and cultural literacy by promoting valuable relationships with peers and adult facilitators through activities, dialogue, and self-expression. An interview with the program director revealed the program utilizes The Council for Boys and Young Men curriculum for gender specific programming.

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

The program has a written facility operating procedure (FOP), concerning internal alert system. The FOP provided direction on how alerts are identified, documented, updated, and communicated to employees. The program utilizes the Department's Juvenile Justice Information System (JJIS), for entering and removing alerts on identified youth. A crosswalk between those alerts contained within JJIS and the program's internal alerts were consistent with one another. A discussion between each team member for mental health, medical, case management, and safety and security found evidence all youth were placed within the programs internal alert system. A review of the program's logbook documentation found youth were removed or downgraded from alert status by appropriate staff. The program director was interviewed and stated JJIS is reviewed for any closed or open alerts on youth at the pre-staffing. The program's medical unit is responsible for entering and closing alerts in JJIS. Internal alert logs are created daily and signed by staff. Management reviews the daily alert log and sign off. Program compliance monitors the alerts to ensure fidelity is maintained. A review sample of seven internal alerts was conducted. Each alert was clearly identified on date the alert was entered into JJIS. For those alerts which were recommended to be downgraded or otherwise discontinued, each was completed by appropriate staff in order to do so.

Documentation was found within the program's logbook identifying alert status as needed. Five staff were interviewed, each were able to articulate how they were informed of youth's alerts; alert log, shift briefing, and daily logs.

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

The program maintains separate youth records for healthcare, mental health, and case management. Five individual case management records were reviewed. Each record included a file tab which identified the following information: youth name, Department of Juvenile Justice identification number, date of birth, county of residence, and committing offense. The youths' individual management records are divided into the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous section. All youth records were labeled 'confidential'. All healthcare, mental health, and case management records were found to be secured in locked offices or filing cabinets, which were marked with 'confidential'.

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

The program has a formal process to promote constructive input by youth. This process is developed through the utilization of student advisory council, student interviews, suggestion box, and exit surveys. Documentation was reviewed of student advisory council meeting, agendas, sign-in sheets, and interviews/surveys. The program meets at a minimum monthly to address and listen to youth input. Five youth were interviewed concerning the process which allows youth to provide input about what happens at the program. Each youth agreed they had a process in place which gave them the ability to provide input. All five-youth stated this is primarily accomplished through the programs house meetings. The program director was asked to explain the formal process the program uses to solicit input from youth to which he indicated the program has youth council. The youth counselor not only has the ability to provide input at program level but are also allowed to provide input directly to headquarters, AMIkids, Inc. senior vice president of operations by telephone and on video. The program also has a "411" system, whereby any youth can provide input to any staff to pass on. The program conducts large general group to address issues and concerns.

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

The program conducts at a minimum, quarterly community advisory board meetings. A review of meeting minutes, sign-in sheets, and agendas supports the program having continually conducted community advisory board meetings at least quarterly. The program solicits active involvement from participants by electronic notification. The participants represent areas such as law enforcement, judiciary, community and business partners, school board, and victim

advocate. The program did not have a representative from the faith community or a parent/guardian whose child was previously involved in the juvenile justice system.

An interview with the program director was conducted in order to describe the program's advisory board and indicated The AMIkids Pensacola Board of Trustees currently consist of nine voting members. The Board of Trustees is an active board which meets regularly the fourth Tuesday of each month. The members have voting authority on all matters relating to properties, vehicles, and restricted funding which is owned by AMIkids outside of any contractual obligations with the Department of Juvenile Justice. As such, the board reviews regularly the financial statements for the program, make recommendations on special events/activities, and conducts fund raising and grant writing on behalf of the program and the youth assigned. An example of their involvement was a special fund raiser, where they sponsored a comedy night here in the Pensacola area. Another example would be money received from the BEAR foundation in support of summer and winter challenge games, which the program youth participates in. Another example would be the grant submitted to IMPACT 100 to secure a carpentry workshop for the vocational training being conducted at our sister school here in Pensacola. Most of the youth involved in the carpentry vocation currently come from Escambia Boys Base. They also secured funds to assist in the renovation of the kitchen area in the program's day school where youth train for their food service certification. The Board of Trustees make recommendations as to the kinds of safe guards, which could be put in place in the handling of restrictive funds and donations. A telephonic interview was conducted with a member of the program's advisory board. The individual confirmed their participation in the meetings, which he attends regularly.

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

The program had a written facility operating procedure (FOP), which allowed for inclusion of information from a variety of sources to ensure staff are informed of programmatic issues. In addition, the program includes information obtained from youth and parent/guardian surveys to solicit input and provide feedback on operations. The program management team meets at least quarterly to assess programming, which includes staff retention, morale, and overall operation of the program. In order to improve upon facility operations, the program captures data obtained from input through surveys provided to staff, youth, and parents/guardians. The program provides youth and staff with a survey at least quarterly. Youth are also encouraged to give input at treatment teams. In addition, youth are surveyed at their exit from the program. Parents/guardians are also surveyed at the youth's exit for their input. Staff members are solicited during staff meetings for their feedback and input into programming. The AMIKids produces an annual report called outputs and outcomes report. The report is data driven to measure and provide input into AMIKids planning. The program director ensures systems of communication is established between management and staff for input and feedback. Staff retention is in place to assist and minimize turnover and boost employee morale. Staff meetings, both all-hands and management meetings occur monthly, as noted through sign-in sheets and agendas since last annual compliance review.

An interview with the program director was conducted and indicated weekly management meetings are held with all key units. There is a regular weekly supervision workshop with the treatment team and a monthly general staff meeting. The director also stated all staff participate in five-year planning and FOP review. Information is trained in an annual workshop and board meeting. Annual goals and objectives are set based on outcomes and recommended

improvement areas. Information is shared with staff in the monthly meetings and at the annual distribution of the CAR Report, outcome reports, monthly statistical reports, and quarterly regional director meetings.

Five staff were interviewed and asked, how often are staff meetings held. Three staff responded bi-weekly and two staff replied monthly. Staff further explained those topics discussed during staff meetings ranged from, youth updates, staff concerns, training, grading point cards, cleanliness, youth precautions, night checks, vehicle operation, and coaching of youth to name a few. All five-staff agreed, communication amongst staff at the program is good.

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 facility operating procedure (FOP) which guided the program's system for evaluating staff, performance standards and frequency of evaluations. A review of job positions/descriptions was conducted to ensure each staff members performance standards are clearly identifiable. A review of sample performance evaluations was conducted to ensure the program conducted performance evaluations annually as stated within their FOP. Upon hire and annually, each employee receives a job description which specifies required qualifications, job functions, and performance standards. The employee reviews and signs his/her job description and evaluation as they occur. A crosswalk of performance standards and job descriptions, demonstrate expectations match for each staff. An interview with the program director was conducted to determine the program's annual evaluation process for each staff position and stated all staff are assigned a supervisor who writes annual evaluations which allows for feedback and comments from staff and includes recommended improvement areas.

Standard 2: Assessment and Performance Plan

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

Five youth case management records were reviewed for initial parent/guardian contact by telephone within twenty-four hours of admission. All five case management records had documentation which parents/guardians were contacted within twenty-four hours of the youth's admission to the program. All five youth records also contained documentation the parents/guardians were also notified in writing within forty-eight hours of the youth's admission. In all five youth records the courts and juvenile probation officers were notified in writing within five days of admission.

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

Five youth case management records were reviewed for orientation requirements. All five records had documentation the youth received orientation to begin on their day of admission. The orientation packet contained in each youth's record included services available, daily schedule, expectations and responsibilities of youth, the program's written behavioral management system, mental health and medical availability and services, numbers and access to the Florida Abuse Hotline and Central Communications Center, contraband items, dress code and hygiene practices, procedures on visitation mail, and use of telephone. The youth's anticipated length of stay is included in the orientation packet along with the program expectations for release, to include individual performance plan goals, program's recommendations to the court, and the court's decision to release. All community access information is included in the orientation packet. In addition, emergency procedures, all procedures for fire drills and building evacuations, physical design of the program, assignment to a living unit, room, and treatment team schedule are included in the orientation packet.

A youth admission was observed during the annual compliance review which included observations of all elements as outlined in the program's policy. A review of the program's logbook validated the orientation process.

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

The program 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. Five youth case management records were reviewed, of which three were applicable. Each record contained documentation of each youth's provision of a signature and date consenting to release of information to the 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 that may be used as potential weapons or means of escape, or participation in any off-campus activity.*	

Five youth case management records were reviewed for classifications factors, procedures, and reassessment for activities. All five case management records contained an initial classification form which included all of the required elements. In each of the five youth case management records reviewed, the program documented a review of any Juvenile Justice Information System (JJIS) alerts for any issues affecting classification. The youth were classified for purposes of assigning to a living area and sleeping room. Any medical, mental health, substance abuse, security risk factors, and/or special needs identified during or subsequent to the classification process were entered into the program's internal system. Five youth case management records were reviewed, of which four were applicable. The four case management records contained documentation of the classification being entered into JJIS.

Five youth case management records were reviewed for classification reassessments. All five records contained reclassification documents to include an increase in the youth's 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, and participation in off-campus activities.

The program's policy and procedures clearly outline the classification process and include a classification system which promotes safety and security, as well as effective delivery of treatment services, based on determination of each youth's individual needs and risk factors, which addresses, at a minimum, items outlined in Florida Administrative Rule. The policy also addressed when reassessment is warranted based upon changes in the youth's supervision status, new or updated alerts, relevant information available to the treatment team, and/or behavioral concerns. Five case management records were reviewed, and it was confirmed the program has continually updated the internal alert system which is easily accessible to program staff and keeps them alerted about youth who are security or safety risks, including escape risks, suicide or other mental health risks, medical risks, sexual predator risks, and other assaultive or violent behavior risks.

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

The program maintains a binder containing all known gang identification for youth in the program. Five youth case management records were reviewed, of which three youth records contained documentation of gang affiliation. Each record had documentation local law enforcement was notified of suspected gang activity by the program. There was documentation the youth's home county was notified in all three records. Each reviewed record had documentation of the gang status being shared with the educational provider at the program, and the youth's juvenile probation officer.

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

The program provides Impact of Crime (IOC) and a gang awareness group to the youth within the program. Five youth case management records were reviewed, of which three youth were identified as being affiliated with gang members. Each of the three applicable youth records contained documentation of the youth participating in gang prevention and intervention activities. Each youth identified as gang affiliate had documentation of the gang interventions and strategies in their performance plans. The program conducts IOC groups, maintains a gang binder with activities for the youth, the gang coordinator conducts meetings with the youth. The program maintains a binder with gang training and information, to include gang drawings and symbols.

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

Five youth case management records were reviewed to ensure an initial Residential Positive Achievement Change Tool (R-PACT) assessment is conducted within thirty days of admission. Each youth record had an R-PACT assessment completed within the required timeframe. The initial assessments were also maintained in the Department's Juvenile Justice Information System (JJIS).

Five youth case management records were reviewed to ensure the R-PACT reassessment was completed within ninety-days after completion of the initial R-PACT assessment. Four of the five youth records had documentation the R-PACT reassessments were completed timely. One of the youth records indicated the youth had been arrested and would be returning to the program; therefore, the youth was not in the program when the youth's reassessment was due. One of the five youth records indicated a R-PACT reassessment was completed when deemed

necessary by the treatment team to effectively manage the youth's case. All R-PACT reassessment documentation was maintained in the youth's official case management record.

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

Five youth case management records were reviewed for completion of the Youth Needs Assessment Summary (YNAS). Four of the five were completed within thirty days of the youths' admission to the program. One of the five youth case management records contained a YNAS completed one day later than the required thirty-day requirement. All YNAS reports were documented in the Department's Juvenile Justice Information System (JJIS).

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

The treatment team, including the youth, meet and develop the performance plan, based on the findings of the initial assessment of the youth, within thirty days of admission. Five youth case management records were reviewed and contained documentation all five performance plans were developed within thirty days of the youths' admission, and each performance plan was developed after the initial assessment. Five youth performance plans were reviewed and signed by the youth, intervention and treatment team leader and all parties who have significant responsibility in goal completion. Four of the five case management records had documentation of parent/guardian signature sheet was returned to the program, was attached to the original performance plan, and filed in the youth's official case record. All five youth had individualized goals and was based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process. Each of the goals contained target dates for completion, youth responsibilities and staff responsibilities. Four of the five reviewed performance plans did not include the top three criminogenic needs identified for the youth, and no reason was documented in the case management file as to why these were not included. Each plan was reviewed did include specific delinquency interventions, with measurable outcomes which will decrease criminogenic risk factors and promote strengths, skills, and supports to reduce the likelihood of the youth reoffending. All five youth performance plans included target court-ordered sanctions which can be reasonably initiated/completed while in the program. All five performance plans were sent to the juvenile probation officer, the committing court, and the parent/guardian within ten days of completion.

Five interviewed youth reported participating in the development of their performance plan and knew their current performance plan goals. Each of the interviewed youth reported having a copy of their performance plan.

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.	

Performance plan reviews result in revisions to the youth's performance plan when determined necessary by the intervention and treatment team. Five youth case management records were reviewed for revisions to the performance plans. Two of the five youths' performance plans were revised due to changes on the Residential Positive Achievement Change Tool (R-PACT) and newly acquired information. Three youth had R-PACT reports which did not warrant an update to the performance plan. All five youth performance plan revisions documented the youth demonstrated progress and lack of progress towards completing their goals. Two of the five youth performance plan revisions were needed to facilitate transition activities during the last sixty days of the youths' stay. Three of the youth case management records reviewed indicated these youth were not yet in transition.

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

Five youth case management records were reviewed for performance summaries. Three of the performance summaries were completed every ninety calendar days following signing of the performance plans. One performance summary was completed one day late. One youth was not eligible for a performance summary as the youth had not been at the program long enough. Two of the five youth case management records reviewed provided documentation the performance summary was prepared prior to the youth's release from the program. Three of the youth were not eligible for the request to leave the program.

Four of the five youth case management performance summaries included the youths' status on each goal, overall treatment progress, academic status, grades, credits earned in the program, performance and behavior in school, youth's overall behavior, level of motivation and readiness to change, interaction with peers, interaction with staff, overall behavior adjustment to the program, and significant positive and negative events. Two of the five reviewed performance summaries included a justification for release from the program. Three of the youth were not requesting release. Four of the five youth case management records reviewed provided documentation the youth were provided comments prior to signing the performance summary, the youth was provided a copy of the performance summary, and the original performance summary was located in all four case management records.

Four of the five reviewed case management records reviewed provided documentation the performance summaries were signed by the treatment team leader, treatment team leader, program director or designee, and youth. Four of the five case records included documentation a copy of the performance summary was mailed within ten working days of the signature date to the committing court, youths' juvenile probation officers, youth, and the parent or guardian.

Three of the five case management records reviewed included documentation of a Pre-Release Notification (PRN) to the juvenile probation officer. The PRN was sent along with the initial performance summary within the required timeframe. The signed copy of the PRN is retained in the youths' case management record.

Seven youth case management records were reviewed for court objections to the PRN notifications. None of the youth case management records had a rejection to the PRN.

Three closed youth case management records were reviewed for the written notification of the youth's planned release. All three closed case records included written notification to the youth's parent of planned release. All three closed youth case management records documented an exit Residential Positive Achievement Change Tool (R-PACT). All five youth interviews of the youth indicated all youth received a copy of their performance summaries which were sent to 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 the involvement of the youth's parent/guardian in the case management process. Five youth case management records were reviewed for parental involvement in case management services. Youth records contained evidence of parent/guardian participation in the youths' assessment process, participation in the development of the youths' performance plan, and progress reviews. Five youth case management records contained evidence of all parent/guardians being notified and participated in formal treatment team meetings. There was evidence in all reviewed case management records of parents/guardians participating by telephone. According to a review of the provider's contract, it was determined the outlined performance expectations are being met. During the annual compliance review a treatment team was observed. Four treatment team meetings were held during the annual compliance review week and observed by the review team member. Three of the four parents/guardians attended the treatment team by telephone and one parent/guardian attended the treatment team in person. Five youth case management records documented the parents/guardians were notified with correspondence of all treatment team meetings. The program also sends invitations by emails, telephone calls, and letters for visitation days and program activities to be able to attend. Five youth were interviewed and reported the parents/guardians are invited to participate in case management services by telephone.

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

The youth's assigned case manager serves as the treatment team leader. Five case management records were reviewed for the representatives included in treatment teams. Treatment team members include the youth's case manager, youth, administrative representative, direct care staff, treatment staff, educational staff, Department of Children and Families case worker, juvenile probation officer, parent/guardian, and transition coordinator.

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 performance plan. All five youth had an academic plan and a separate mental health treatment plan. One of the five youth has a Department of Children and Families (DCF) case plan which was not incorporated into the performance plan. The youth's case management record did not include legal documentation or the youth's DCF case plan.

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

The formal treatment team meeting occurs every twenty-eight days, unless scheduling conflicts require it be moved. Each youth is assigned a specific date and time of their treatment team to attend. During formal treatment teams all parties are encouraged to attend to include the youth's juvenile probation officer, parent/guardian, case manager, nursing staff, direct care staff, transition coordinator, therapist, and teacher or education representative. Five case management records reviewed documented a formal treatment team packet, which included a form from case management, an education packet, and a nursing form. Five treatment team packets included the youths' name, date of review, meeting attendees, administrative personnel or representative, direct care staff, education staff, medical staff, parent/guardian, and juvenile probation officer (JPO). All treatment teams were conducted on a monthly basis during the annual compliance review period. The treatment team packet included any comments from the treatment team members and other attendees, brief synopsis of the youths' progress, performance plan revisions, performance plan goals, positive and negative behaviors, treatment progress, and Residential Positive Achievement Change Tool (R-PACT) results. Five youth treatment team packets indicated the five youth did not have behaviors resulting in physical interventions. All five youth were able to demonstrate skills acquired in the program.

Five youth case management records indicated informal treatment team reviews are held on a bi-weekly basis. Informal treatment team reviews are documented on a separate packet. The informal treatment team reviews include the youths' name, date of review, meeting attendees, comments from treatment team members and others, synopsis of the youths' progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, treatment progress, and changes on the R-PACT results. Five youth treatment team packets indicated all youth did not have behaviors resulting in physical altercations. All five youth were provided an opportunity to demonstrate skills acquired in the program. The five treatment team packets and the Juvenile Justice Information System (JJIS) is updated and least every ninety days and at the sixty-day transition conference.

A formal treatment team was observed during the annual compliance review. A copy of the treatment plan was reviewed for all four-youth attending treatment team. All required staff were present or a representative from the program department was present to include: case manager for the youth, nursing staff, direct care staff, therapist for the youth, and the transition specialist. A representative from education was not present for the formal treatment team, but the case manager had an education packet available and shared the information during the treatment team. Four treatment team packets were reviewed and included the youths' progress on performance plan goals, positive and negative behaviors were discussed, youths' treatment progress discussed, all members actively participated in the youth's treatment team. All members allowed the parent/guardian and JPO time for questions and feedback. All four youth were provided an opportunity to demonstrate skills acquired in the program. Five youth were interviewed and reported they are provided the opportunity during treatment team meetings to demonstrate skills the youth has learned in the program.

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

The program offers Type 2 educational programming and Type 3 certifications. The program works with the youth from admission to collect items required for employment throughout the youths' stay. Five youth case management records were reviewed. Three of the five youth case management records had documentation of the youth completing employment applications. The program allows for the youth to obtain employment while at the program. One of the five youth case management records included a completed résumé summarizing education, work experience, and career training.

None of the youths' case management records included a schedule for appointments at the Career Source Center. The program provided information the Career Source Center refuses to schedule future appointments with the youth while at the program. The program does provide the youth with the phone number and address to the Career Source Center. Two of the five youth case management records contained the appropriate documents essential to obtaining employment. Two of the five youth case management records contained documentation the youths' parent/guardian and juvenile probation office (JPO) were made aware of the youth's vocation plan for the youth.

The program director's interview indicated the following career education services being offered to the youth in the program: Customer Service Certification, Department of Children and Families (DCF) forty-hour childcare certification, Food Handler's Card Certification, Forklift Certification, Oil Change Certification, Florida Ready to Work Certification, Hospitality and

Housekeeping Certification, Basic Automotive Tire Service Certification, Typing Test Certification, Simoniz Express Detail Technician Certification, Cashier Training and Certification, Occupational Safety and Health Administration (OHSA) ten-hour industry training certification, Department of Labor carpentry, and Safe Serve certification.

An interview with the lead educator for career education indicated the following career education services and assessments for the program: career skills, career classes, and employability skills. The youth at the program also have the opportunity to go to the local day treatment program and participate in construction technology.

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

The program will integrate educational instruction into their daily schedule in such a way ensuring the integrity of required instructional time. The program provided the annual compliance review team with the program schedule. The principal of the school at the program provided the daily school schedule and the school year calendar for the program and for the school district. Upon review it was confirmed the youth at the program participate in educational and career-related programs for 250 days of instruction. The principal reported the teachers at the program take scheduled teacher in-service days only if it coincides with the district calendar. All other teacher in-service is conducted after school at the program. The youth receive credits for the educational and training experience at the program. The activity schedule and logbook document minimal interference of educational instruction. The program logbook noted movement to and from school throughout the day. The youth interviews documented there was minimal interference of education instruction.

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

Three closed youth case management records were reviewed for documentation an education transition plan was developed beginning at admission. The three records had an individual education transition plan developed based on youths' post release goals. For all three closed case management records the following participants included the youth, parent/guardian, education representative, post release staff/re-entry personnel, certified school counselor, and a registrar or designee of the program's district. In all three closed records reviewed, a transition plan was developed with youth and program, education, and aftercare staff with specific plans for continuation of education and/or employment. All three closed case management records had education transition plans which included services and interventions based on youths' assessed educational needs and post-release education plans. The education transition plans included the recommended educational placement for post release based on youths' individual needs and performance. All three plans also address the specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services.

Three closed youth case management records were reviewed to verify the youth who have employability as a transition goal included the required information in the educational transition

plan. All three closed youth case management records included provisions for continuation of education and/or employment, a sample completed employment application, a résumé summarizing education, work experience, and/or career training. An appointment with the Career Resource Center within the vicinity where the youth will be seeking employment was not in the case management record. According to the education leadership, the Career Resource Center refuses to set appointments with the youth at the program prior to release. The program does provide the address and phone number for the youths' local Career Resource Center to schedule an appointment when the youth meets with their juvenile probation officer upon release from the program. The three closed youth case management records included the appropriate documents essential to obtaining employment upon leaving the program. All three closed case management records included evidence the youths' case manager and parent/guardian are aware of the education transition plan, documents, and post-release discharge plans.

2.19 Transition Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory Compliance

A residential commitment program shall ensure the intervention and treatment team is planning for the youth's successful transition to the community upon release from the program, when developing each youth's performance plan and throughout its implementation during the youth's stay.

During the transition conference, participants shall review transition activities on the youth's performance plan, revise them if necessary, and identify additional activities/services as needed. Target completion dates and persons responsible for their completion shall be identified during the conference. The intervention and treatment team leader shall obtain conference attendees' dated signatures, representing their acknowledgement of the transition activities and accountability for their completion pursuant to the youth's performance plan.

Each youth must attend their scheduled Community Re-entry Team (CRT) meeting prior to discharge.

Three closed case management records were reviewed for transition conference requirements. All three records contained evidence of a transition conference date held sixty days prior to youths' release. All three records contained the appropriate documents essential to obtaining employment upon leaving the program. All three records contained evidence the youths' case manager and parent/guardian were aware of the plan, documents, and post-release discharge plans.

Three closed case management records were reviewed for transition conference documentation. All records included signatures for the following attendees: youth, treatment team leader, program director or designee, and other team members. All records included documentation the following participants were invited to attend or participated in the transition conference: juvenile probation officer, parent/guardian, education staff, and any other pertinent parties.

Each of the records included documentation of transition activities on the performance plans, revised performance plans if necessary, identified additional transition activities, identified target completion dates, and identified persons responsible for completion. All three transition conference forms included the attendees' dated signature. Documentation in all three closed case management records confirmed copies of the three transition plans were sent with a

request for return with signature to anyone not in attendance who has a responsibility for completion of transition goals. Three closed case management records were reviewed for documentation of the Community Re-entry Team (CRT) meeting. All three closed records had documentation of a CRT meeting being conducted prior to the youths' release and invitations being sent to participate. All three records also had documentation the youth and case manager participated in the CRT.

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

Three closed case management records were reviewed for exit portfolios. All three closed records contained evidence the exit portfolio was discussed and initiated for the youth at the transition conference. The following items were located in all three closed records: state-issued identification card, copy of the youth's transition plan, calendar with all dates/times/locations of follow-up appointments in the community.

The three closed case management records included documentation of the social security cards, birth certificates, vocation certificates earned in the program, all educational records, school transcripts, a résumé, and a completed sample job applications for all of the youth. There was evidence the education staff forwarded the exit portfolio information to the receiving district. The transition specialist also forwards the education portfolio to the family and provides a copy to the youth upon leaving the program. All three closed case management records had documentation the youths' exit portfolio was verified at the exit conference and the was completed and given to the youth upon completion of the program. The provider's residential contract was reviewed to ensure the program is meeting all requirements, in addition to administrative rule.

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

Three closed case management records were reviewed for exit conferences. There was evidence all three exit conferences were conducted after the program notified the juvenile probation officer (JPO) of the release. All of the exit conferences were conducted at least fourteen days prior to the youths' release from the program. The exit conference attendance form was in all three closed case management records and included the date, signatures, and a summary pending transition goals. The date of admission and the date of termination documented in the case file correlated with the Department's Juvenile Justice Information System. All three closed case records reviewed the status of transition activities established at the transition conference and finalized the plans for the youths' release. The following participants attended the exit conference: treatment team leader, parent/guardian, and education representative.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health professional; a licensed mental health counselor (LMHC), who serves as the Designated Mental Health Clinician Authority (DMHCA), licensed under chapter 491, Florida Statutes. A review of the license through the Florida Department of Health (DOH), reveals it is clear and active, and expires March 31, 2019. The DMHCA is employed full-time and is on-site forty hours a week, five days a week and every third weekend. A copy of the license and position description was available on-site. Licensure and position descriptions are readily available on-site for all mental health and substance abuse staff at the program.

An interview was conducted with the DMHCA, and indicated the DMHCA is responsible for overseeing all mental health/substance abuse services at the program. The GMHCA meets with the clinical case managers, therapist, the recreation therapist, and the transition coordinator throughout the week for supervision and holds a formal weekly meeting. The DMHCA indicated she is available by phone 24/7 to assist as needed. When a new youth is admitted to the program, he is staffed by the treatment team and services are tentatively identified. During weekly and/or individual supervision, the DMHCA will determine what furhter services the youth needs to ensure he is placed in the appropriate groups.

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

The program's mental health and substance abuse staffing is in accordance with the program's contract and Florida Administrative Code, 63N-1. The designated mental health authority (DMHA) is a licensed mental health counselor (LMHC), licensed under chapter 491, Florida Statutes. A review of the LMHC's license through the Florida Department of Health (DOH), reveals the license is clear and active, and expires March 31, 2019. The program has an agreement with a psychiatrist, who has completed psychiatry certification by the by the American Board of Psychiatry and Neurology, licensed under chapter 459, Florida Statute. The psychiatrist's license is clear and active, verified through DOH, and expires January 31, 2020. The program is licensed in accordance with Chapter 397, Florida Statute, to provide substance abuse services, certified by the Department of Children and Families (DCF), which expires August 4, 2019.

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

The program has two non-licensed clinical staff providing mental health and substance abuse services at the program. The clinical supervisor is the Designated Mental Health Clinician Authority (DMHCA) who is also a licensed mental health counselor (LMHC). The DMHCA ensures the two non-licensed clinical staff working under their supervision are performing services for which they are qualified. This is accomplished through weekly on-site, face-to-face interaction with the non-licensed clinical staff, lasting at least one hour for each therapist. Each of the reviewed face-to-face supervisions conducted were recorded on a similar form to the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form (MHSA 019), which included all necessary information. Each of the non-licensed clinical staff hold the appropriate levels of education and training necessary in accordance with contract. The non-licensed clinical staff hold master's-level degrees from accredited universities in the field of mental health counseling and social work. The program is licensed under Chapter 397, to provide substance abuse treatment services; certified by the Department of Children and Families (DCF), which expires August 4, 2019. The two non-licensed clinical staff received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services.

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

The program has written facility operating procedures (FOP) addressing the implementation of a standardized admission and intake mental health and substance abuse screening process. The standardized screening process includes a review of commitment packet information, and administration of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) in the Department's Juvenile Justice Information System (JJIS). A referral is made for youth identified by the MAYSI-2 as in need of further evaluation or immediate attention. Five youth records were reviewed for a mental health and substance abuse admission screening. All five youth had a MAYSI-2 completed upon admission. Each of the MAYSI-2 screenings were completed on the date of youth's admission to the program in a confidential manner. The MAYSI-2 screenings were administered in JJIS by staff who have completed the training. One of the five youth who was administered the MAYSI-2 screening, indicated further assessment was required. Four of the five youth who were administered the MAYSI-2, had an override made by staff, making a referral necessary. Three of the four staff override referrals were for the youth requiring an Assessment of Suicide Risk (ASR). In all four instances, an ASR was conducted for youth within an hour, which met the twenty-four hour requirement. All five youth received a comprehensive evaluation based on four overrides and one MAYSI-2 referral. Each of the applicable youth records had a reason for referral documented. There were no youth of the five youth records reviewed, requiring a need for a crisis assessment or emergency services at the time of admission.

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.	

Five youth records were reviewed for completion of a mental health and substance abuse assessment/evaluation. All five youth records reviewed had a new mental health evaluation completed within thirty calendar days of admission. Five of the mental health evaluations were completed by a non-licensed mental health clinical staff person and were reviewed and signed within ten days by a licensed mental health counselor (LHMC). All five mental health evaluations contained the following: identifying information, reason for evaluation, relevant background information, behavioral observation, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression (which included Diagnostic Statistical Manual (DSM) diagnosis), and recommendations. The assessment used for all youth contained the substance abuse evaluation for youth who were identified with substance abuse diagnosis. Two of the five reviewed youth records required completion of the substance abuse portion of the assessment. As the mental health assessment and substance abuse assessment are the same assessment to evaluation youth, the substance abuse assessment was also completed within thirty calendar days of admission, gave a reason for the referral, and contained all the required elements in reviewing the youth. The two of five substance abuse assessments were completed under licensure Chapter 397, Florida Statutes, for substance abuse and all five youth signed a consent form for substance abuse treatment.

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.*	

Five youth records were reviewed for mental health and substance abuse treatment. All records recorded the assignment to a therapist upon admission. Interview with the Designated Mental Health Clinician Authority (DMHCA) reported each therapist is assigned to a treatment team. Therefore, when a youth is assigned to the therapist, they are assigned to a multidisciplinary treatment team attached to said therapist. Each of the youth's multidisciplinary treatment teams were comprised of the youth, parent/guardian when possible, and representatives from administration, education, vocational training, medical staff, mental health staff, and other staff responsible for delinquency intervention and treatment services for the youth. A multidisciplinary treatment team was observed during the annual compliance review and confirmed participants and protocol documented. Each of the five youth records reviewed for mental health treatment, had a properly executed Authority to Evaluate and Treatment (AET) form. All five youth records had the youth sign a consent and release form for substance abuse treatment.

The program completed required mental health and or substance abuse treatment notes on the provider's form, which contained all the information contained within the Department's Counseling/Therapy Progress Note form. Each youth was in receipt of individual, group, and

family counseling. Two of the five youth reviewed were determined to need, and received, substance abuse treatment. Substance abuse treatment was provided by a licensed qualified professional or a non-licensed substance abuse clinical staff, who is an employee of the service provider under Chapter 397, Florida Statutes and under the supervision of the DMHCA. In an interview with the DMHCA and technical assistant for Standardized Program Evaluation Protocol (SPEP) confirmed mental health groups are limited to ten youth and substance abuse groups are limited to fifteen youth. All mental health overlay service groups were observed during the annual compliance review. Youth receive psychosocial skills training in the Mental Health Overlay Services (MHOS) group provided daily. Services are discussed with the therapist and DMHCA during clinical supervision, groups are monitored at random, and documentation is routinely reviewed. Each of the interviewed staff reported they do not facilitate mental health or substance abuse groups.

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

Five youth records were reviewed for treatment planning. All five youth records contained an initial mental health and substance abuse treatment plan developed on the day of admission. All five of the initial mental health and substance abuse treatment plans include all of the information on the Department's Initial Mental Health/Substance Abuse Treatment Plan form (MHSA 015). Four of the five youth records reviewed had an initial treatment plan completed by non-licensed staff with a licensed Designated Mental Health Clinician Authority (DMHCA) review and signature within ten days. One of the initial treatment plans was completed by the DMHCA. Each of the five initial treatment plans were signed by all treatment team members who participated in the development of the plan. Two of the five reviewed youth records indicated the youth was on psychotropic medications upon arrival to the program; however, four of the five youth records included an initial psychiatric diagnostic interview by the psychiatrist. All of the initial psychiatric diagnostic interviews were developed within seven days of the initial treatment plan and included the youth's psychiatric needs, medication, and frequency of monitoring by the psychiatrist. Five youth records were reviewed for completion of individualized treatment plans and reviews. Each of the five youth records contained an individualized treatment plan, which was developed within thirty days of the youth's admission to the program. Each of the five individualized treatment plans were developed on a site-specific form, which contained all of the necessary information on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form (MHSA 016). All five youth individualized treatment plans were completed by a non-licensed mental health clinical staff person. Each of the plans were subsequently reviewed and signed by the program's licensed mental health counselor (LMHC) within ten days of completion. Four of the five individualized treatment plans were signed by treatment team members who participated in development of the plan, along with the youth, and parent/guardian. One youth record was of a foster care youth and documentation showed the plan was sent to the youth's foster care guardian, but the signature was missing. Each of the

individualized treatment plans documented the on-going prescribed services and frequency; including individual, group, family, and/or psychiatric services, as needed. Three youth records were reviewed for discharge plans. Each of the three discharge plans were documented on Department's Mental Health/Substance Abuse Treatment Discharge Summary form (MHSA 011). None of the three youth required any type of notification for suicide risk or precautions. Each of the three mental health and substance treatment discharge summaries documented the services required for daily maintenance. Two of the three discharge plans contained documentation each were discussed at the exit conference and an interview with the case manager confirmed the third discharge summary was discussed at the exit conference. One youth record had a signature missing from the Juvenile Probation Officer (JPO) but documented the discharge summary was sent to the JPO. Another discharge summary had the parent/guardian signature, but no note stating the parent/guardian received a copy.

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

The program provides mental health overlay services only and does not have any specialized treatment services; therefore, this indicator is rated non-applicable.

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

The program has an agreement with a psychiatrist, who has completed psychiatry certification by the American Board of Psychiatry and Neurology and is licensed pursuant to Chapter 459, Florida Statute. The psychiatrist's license is clear and active; verified through the Florida Department of Health (DOH) and expires January 31, 2020. It was reported the psychiatrist is on-site every two weeks, or as needed.

Five youth records were reviewed for psychiatric services. Four of the five youth records reviewed were applicable for a referral of psychiatric services. Each of the initial diagnostic psychiatric interviews included a youth history, mental status examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5), treatment recommendations, prescribed medications (if applicable), explanation of the need for psychotropic medication, and frequency of medication monitoring. All four initial diagnostic interviews with the psychiatrist were documented on the Clinical Psychotropic Progress Note (CPPN) and documented as "initial diagnostic psychiatric interview." Two of the four youth records with an initial psychiatric diagnostic interview continued to take psychotropic medications, but no changes were made to the youth's existing psychotropic medication regimen. Page three of the CPPN was utilized in order to document the psychiatric interview. Each of the two youth with prescription psychotropic medications were seen for a medication review by the psychiatrist every thirty-days.

The program does not have a psychiatric advanced registered nurse practitioner (ARNP). The psychiatrist is on-site every two-weeks and is available to evaluate and monitor youth, as needed. In addition, each youth receives psychotropic medication monitoring and review within thirty days. Pursuant to the agreement between the provider and the psychiatrist, the psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. The psychiatrist provides input to a representative of the treatment team on the psychiatric status of each youth receiving psychiatric services. The briefings are accomplished usually by face-to-face interaction, if necessary, or telephonic communication. The psychiatrist's evaluation and recommendations for the youth is incorporated into the mental health clinical staff's evaluations of the youth and the youth's individualized mental health or substance abuse treatment plan as noted within the two applicable records reviewed. The psychiatrist is ultimately responsible for the prescription and monitoring of psychotropic medications at the program. Interview with mental health staff and medication monitoring documentation confirm the psychiatrist is on-site every two weeks.

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

The program has a written plan detailing suicide prevention procedure. The program's suicide prevention plan includes: identification and assessment of youth at risk of suicide, staff training (total of six hours annually, to include mock drills for all staff), suicide precautions, levels of supervision (one-to-one, constant, and close supervision), referral, communication, notification, documentation, immediate staff response, and a review process. An interview with the Designated Mental Health Clinician Authority (DMHCA) confirmed the program's suicide prevention plan is reviewed annually by the DMHCA and the executive director.

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.*	

Four applicable youth records were reviewed for suicide prevention services. All four youth were determined to be at risk upon admission to the program. Each youth was placed on precautionary observation on admission to the program. An Assessment of Suicide Risk (ASR) referral was generated for each youth during intake. Each of the four youth reviewed had an ASR completed utilizing the required Department ASR form (MHSA 004). All four youth on suicide precaution had a precautionary observation (PO) log completed correctly, including safe housing areas. Each of the three PO logs included documentation supporting supervision occurred with no lapses in or missing observations. Documentation supported the authorization of placement for each youth on PO. A conference was held with the executive director and the

licensed mental health professional to reduce level of supervision. Each of the four youth were placed on constant supervision and stepped down to standard supervision. The parent/guardian was notified by telephone of the youth's potential suicide risk as indicated by the ASR. Three youth records reviewed had an ASR completed by a non-licensed mental health clinical staff under the supervision of a licensed mental health professional. Subsequently, the completed ASRs were reviewed and signed by the program's licensed mental health professional within twenty-four hours. One youth record contained an ASR completed by the Designated Mental Health Clinician Authority (DMHCA). All four of the reviewed youth records were of ASRs completed within an hour of the youth being identified as a suicide risk, which met the required twenty-four hour timeframe. A suicide risk alert was entered into the Department's Juvenile Justice Information System (JJIS), in each of the four youth records reviewed. During the time each youth was on PO, the youth were not limited to an individual cell and could participate in select youth activities. Prior to any of the four youth being transitioned to a lower level of supervision, the non-licensed mental health clinical staff conferred with both the licensed mental health professional and the executive director. Documentation of the actual dates and times the clinician conferred with the licensed mental health professional and executive director were recorded on the ASRs. None of the ASRs were conducted outside of the program. The program does not utilize secure observation.

The program has two separate suicide response kits on-site. One suicide response kit was located within the program's medical office and the other was located in the secure copy room, next to the common room area. Each of the suicide response kits contained a knife-for-life, wire cutters, and needle nose pliers. The program's suicide prevention plan, along with the program integrated mental health crisis intervention and emergency mental health and substance abuse services plan, addresses the executive director's review process for every serious suicide attempt or serious self-inflicted injury. A multidisciplinary review includes, circumstances surrounding the event, facility procedures relevant to the incident, training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations. All five-staff interviewed responded they would notify mental health staff, search the youth and their room for sharp objects, maintain sight and sound of the youth, and document supervision when asked what they were responsible for, should a youth express suicidal thought. Five staff reported a suicide kit was in a "locked cabinet in soft chair area" and four staff reported a suicide kit was located in the medical office.

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.	

Four applicable youth records were reviewed for suicide precaution observation (PO) logs. Each of the four PO logs reviewed were documented on the Department's Suicide Precautions Observation Log form (MHSA 006), and was maintained for the duration the youth was on suicide precautions. All four reviewed PO logs documented the appropriate level of supervision and observations of the youth's behavior. Staff recorded observations of youth behaviors in real time, at a minimum of thirty-minute intervals. None of the records reviewed contained noted warning signs in any of the four-youth's behavior. All four PO logs included specific language documenting safe housing areas within the program. All four PO logs were reviewed and signed off by a shift supervisor. All three PO logs were reviewed and signed off by the mental health clinical staff. Three of the four youth placed on PO of the youth selected for record review, were

available for interview regarding their experience on PO. All three youth were on PO for less than an hour at intake and did not recall being placed on suicide precautionary observation. Two youth reported they were not left alone during intake and one youth reported he was left "alone" in the common room area during intake.

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

A total of five staff records were reviewed for suicide prevention training. Each staff was in receipt of six hours annual training, as required. The program has a written suicide prevention plan, which includes suicide prevention training (to include mock suicide drills) for all staff to participate. The program maintains records of each mock suicide drill conducted with signatures of all participating staff. The program maintains three separate operating shifts; 8:00 a.m. – 4:00 p.m., 4:00 p.m. – 12:00 a.m., and 12:00 a.m. – 8:00 a.m. The program completed mock suicide drills quarterly for each shift. In reviewing mock suicide drills a method for contacting other facility staff by radio or for back-up support to include emergency medical services 9-1-1, and life saving measures such as cardiopulmonary resuscitation (CPR) and/or the use of the suicide response kit were included.

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

The program has a written mental health crisis intervention plan, which is an integrated mental health crisis intervention and emergency mental health and substance abuse services plan. The written integrated mental health crisis intervention and emergency mental health and substance abuse services plan includes, at a minimum, the following: notification and alert system, means of referral (including youth self-referral), communication, supervision (one-to-one, constant, and standard supervision), documentation, and review process. Interview with the Designated Mental Health Clinician Authority (DMHCA), the written integrated mental health crisis intervention and emergency mental health and substance abuse services plan is reviewed and signed by the DMHCA and executive director annually.

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

The program's policy and procedure were reviewed for crisis assessments. There were no youth at the program requiring a crisis assessment during the annual compliance review period. In the past, the program has completed the crisis assessments on the Department's Mental Health and Substance Abuse Crisis Assessment form (MHSA 0023). The program staff are adequately trained to conduct crisis assessments in the event a youth is in need of an evaluation.

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

The program has a written emergency mental health and substance abuse services plan, which is an integrated mental health crisis intervention and emergency mental health and substance abuse services plan. The written integrated mental health crisis intervention and emergency mental health and substance abuse services plan includes, at a minimum, the following: immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health services or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statutes (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statutes (Marchman Act), documentation, training, and review process.

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

One of the five youth records reviewed was applicable for Baker Act. The youth was determined to be in need of emergency care and placed on suicide precautionary observation (PO) at the appropriate time. The youth was supervised one-on-one with mental health staff involved. The youth was removed from the program by the Escambia County Sherriff's Office and placed at the local mental health facility for Baker Act. Upon return to the facility, the youth was placed on PO constant supervision. An Assessment of Suicide Risk (ASR) was completed, including a Mental Status Examination. The youth was maintained on constant supervision until transitioned to a lower supervision of close. Two ASRs were completed by the licensed Designated Mental

Health Clinician Authority (DMHCA) when the youth was placed on constant and moved to close. The youth was then transitioned to standard supervision. All supervision levels change and conferences with the DMHCA and executive director were documented.

Standard 4: Health Services

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

The program has an up-to-date contract with a Florida licensed physician to be at the program one day a week to provide oversight of the medical department, sick calls, chronic care, clinic, and other duties, as needed. The Designated Health Authority (DHA) holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. The DHA is on call twenty-four hours a day, seven days a week for consultation, as needed. The program does not have an advanced registered nurse practitioner (ARNP) on staff. A review of the logbooks over the past six months found the DHA was on-site as required. The DHA will be contacted in the event of a medical emergency with emergency medical services being referred to the local emergency room or other licensed healthcare agency, as needed. The DHA was asked to briefly describe his role at the program, he replied; primary care physician for Escambia Boys Base. Additionally, he was asked how often he was on-site and he replied; once weekly. The DHA was also asked how does he make himself available to staff when not on-site, he replied; available twenty-four hours on call. The DHA was also asked if he had a designee for on-site clinical services, he replied; no designee. The DHA was asked, how do you ensure all off-site care findings, instructions, and information is reviewed by you, he replied; medical staff provide all off-site care summaries, sick calls, lab results, for review weekly. Documentation of reviews are located in each youth record. The DHA was asked about what formalized procedure is in place with the healthcare staff to review important medical issues, he replied; available twenty-four hours a day, seven days a week on-call for any medical concerns, emergency care, and coordination of off-site care. Additionally, he confirmed he is on-site weekly. He was asked, how often are periodic evaluations are conducted for youth with chronic conditions, he replied; monthly and this is accomplished by using a chronic log schedule. The DHA was asked about coverage while on vacation or schedule abscences, he replied; he has an agreement with another medical doctor to provide coverage. The DHA had no concerns with the health care at this program.

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

The Designated Health Authority (DHA) and program director, signed and dated all respective treatment protocols and written facility operating procedures (FOP) at the program. Each of the nursing staff at the program have reviewed, signed, and dated a cover page on which all FOPs, treatment protocols, and other procedures are listed, this is accomplished annually. In addition, those new policies or changes within FOPs which were made during the year were reviewed, signed, and dated by each nurse. Newly hired health care personnel received a comprehensive clinical orientation to the Department's health care policies and procedures, which were facilitated by the on-site registered nurse. Each of the treatment protocols were addressed and authorized by the DHA; there was no indication they were delegated to any other person. The review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management is performed by the program's psychiatrist. A review of the program's written health-related policies, procedures, and protocols was conducted, in order to ensure they properly outlined the program's health care services.

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

Five youth individual healthcare records (IHCR) were reviewed for Authority for Evaluation and Treatment (AET). Two youth IHCRs had the original AET filed and the remaining three youth records contained copies. The three records with copies had the word “copy” stamped on the AET. One record did also contain a court order, which was filed in the youth’s medical record. Four of the five youth records reviewed, had an AET which was valid for as long as the youth is under supervision, custody, or other form of legal control. The one remaining youth had an applicable court order and additionally under supervision of the Department of Children and Families (DCF). Four of five youth IHCRs had copies of completed parental notifications maintained behind the AET. The remaining one youth, is under supervision of DCF, and a court order was maintained in this youth’s IHCR.

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

Five youth individual healthcare records (IHCRs) were reviewed for parental notification. Four out of five youth IHCRs contained documentation of parental notification for over-the-counter (OTC) medications beyond those covered by the Authority for Evaluation and Treatment (AET). The remaining one youth, is under supervision of the Department of Children and Families (DCF) and had an applicable court order. Two of the five reviewed IHCRs, were applicable for significant changes to existing medication regime. None of the five-youth required discontinuation of medication prescribed prior to youth entering custody of the Department. None of the five youth required any changes in condition for youth with chronic conditions. None of the five-youth required notification for off-site emergency care. Three youth were applicable and had notifications for when the youth was taken off-site for medical treatment. Four of the five youth had notifications for new medications; verbal attempts to the parent/guardian were found within the youth’s medical record under progress notes. In each of the cases, where telephonic notifications occurred, the program followed up with written notifications. Each case where telephonic notification occurred, each call was witnessed. For the one youth under supervision by DCF, the court authorized all treatment.

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

Five youth medical records were reviewed for notification/consent to the parent/guardian for the prescription of new psychotropic medications, discontinuances, or adjustments; only three youth were applicable. The Clinical Psychotropic Progress Note (CPPN) was utilized to provide notification to the parent/guardian. For each youth when a psychotropic medication is initially prescribed, discontinued, and/or significant dosage adjustment is made, parent/guardian notification and consent was obtained. Each youth had a notification mailed along with the CPPN (pg. 3) and explanatory information, for the initiation of psychotropic medication. Only one youth required notification to be sent for significant changes or discontinuation of psychotropic medication. Two youth records were applicable for verbal consent to be obtained

for the CPPN. A staff member witnessed all telephone call attempts and conversations made and documentation of these witnessed conversations was found documented on the CPPN. In addition, documentation of the CPPNs sent to the parent/guardian for consent, also confirmed the parent/guardian signatures for each CPPN.

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

Five youth individual healthcare records (IHCRs) were reviewed for immunizations. Each of the five youth had vaccinations, which were verified within thirty days of the youth admission. Each applicable IHCR, had consent obtained prior to administering the vaccinations within thirty days of the youth admission. None of the reviewed IHCRs were applicable for "Religious Exemption from Immunization". In addition, none of the five reviewed IHCRs were applicable and did not require a consent to a vaccination for medical reasons by the parent/guardian. An interview with nursing staff was conducted and asked how nursing staff determines how immunizations records are obtained, nursing staff replied; A signed letter is provided to the facility by the youth health care provider indicating the reason for the exemption and a copy is filed in the youth IHCR.

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

All five youth individual healthcare records reviewed contained a completed Facility Entry Physical Health Screening (FEPHS) form. Each of the FEPHS were completed by a registered nurse (RN) on the date of admission. None of the FEPHS were completed by direct care staff.

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

Five youth individual healthcare records (IHCRs) were reviewed for medical alerts. Three of the five youth were identified with a chronic condition. Three youth were classified with a medical grade three or higher. None of the youth were applicable for any allergies. One youth was identified with medication interactions. None of the youth had any noted head trauma or injury. None of the youth were identified in having a hearing, speech, visual, or physical impairment. Two youth were identified as having medication side-effects. In each case, nursing staff verifies all medical alerts are up-to-date. In a crosswalk with the program's internal alerts and the youth's alert in the IHCR confirmed each matched, as required.

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

Five youth individual healthcare records (IHCRs) were reviewed for youth orientation to healthcare services. All five youth were in receipt of a health care orientation upon admission to

the program. The healthcare orientation topics include: access to medical care, sick call, what constitutes an "emergency" and when to notify staff, medication process to include side-effect monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care providers. A review of healthcare contacts was conducted and verified to be accurate. The program has a written facility operating procedure (FOP) which addresses youth orientation to healthcare services.

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

Five youth individual healthcare records (IHCRs) were reviewed for designated health authority (DHA) notification upon admission for youth who are admitted with known or suspected chronic conditions. Three of the five youth IHCRs reviewed were applicable for notification to the DHA. Each of the three IHCRs had notification to the DHA. One youth out of the three had documentation the DHA was notified by telephone. The other two remaining youth were seen by the DHA, making notification verbally. One youth was applicable out of the five-youth reviewed, as in need of an emergency response. The DHA was notified by telephone.

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

Five youth individual healthcare records (IHCRs) were reviewed for healthcare admission rescreening. Three youth were applicable for a healthcare rescreening. Each time the program completed a new Facility Entry Physical Health Screening (FEPHS) re-screening upon his return. Each FEPHS was completed by either registered nurse (RN), licensed practical nurse (LPN), direct care staff, or medical doctor. None of the completed FEPHS were conducted by direct care staff.

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

Five youth individual healthcare records (IHCRs) were reviewed for Health-Related History (HRH). All five HRHs reviewed were completed within seven days of the youth admission to the program. Each of the HRHs were completed by a licensed nurse or the Designated Health Authority (DHA). There was an indication for each of the IHCRs reviewed, confirming the DHA reviewed the HRH. A checkbox on the Comprehensive Physical Assessment (CPA) was marked indicating the HRH had been reviewed. In each of the five IHCRs reviewed, the HRH was completed before or at the same time as the CPA.

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

Five youth individual healthcare records (IHCRs) were reviewed for completion of Comprehensive Physical Assessment (CPA) form. Each of the youth reviewed had a completed CPA form. The program uses the Department's CPA form. Each of the five IHCRs reviewed had a current CPA on file at the time of admission. Each of the CPA's were completed by the program's Designated Health Authority (DHA). The CPA had an appropriate medical grade indicated. The CPA was completed in accordance with Florida Administrative Code requirements. All sections of the CPA were marked with either an "O" or an "X". In each of the five-youth IHCRs reviewed, each had the problem list updated as required.

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

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

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

Five youth individual healthcare records (IHCRs) were reviewed for completion of a Tuberculosis Screening Test (TST). All five youth had at least one verified TST documented within the last year. Each youth had a Tier I TB screening completed within seventy-two hours of admission. Each youth was assessed prior to placement into general population. The results of the TST are documented on the Comprehensive Physical Assessment (CPA) and Infectious and Communicable Diseases (ICD) forms. A review of the program's written facility operating procedure (FOP), was in compliance with the Centers for Disease Control and Prevention new 2006 recommendations and Occupational Safety and Health Standards. The program had a facility operating procedure for addressing tuberculosis screening testing.

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

Five youth individual healthcare records (IHCRs) were reviewed for sexually transmitted infection (STI) screening. All five youth were identified as sexually active and subsequently were clinically screened and evaluated for STIs. Two of the five youth were applicable and required further evaluation as a result of the STI screening. Both youth had the appropriate testing ordered and completed. Documentation was found on the Infectious and Communicable Diseases (ICD) form as required. The two youth had referrals documented on the STI and within progress notes. Appropriate lab results were found filed within the lab section of the youth's individual healthcare record.

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

Five youth individual healthcare records (IHCRs) were reviewed for human immunodeficiency virus (HIV) testing. There was evidence each of the five-youth reviewed were offered counseling, testing, and treatment (referral) for HIV. Four of the five youth requested HIV testing. Each youth had HIV test results filed in a confidential manner consistent with Florida Statute 381.004. Each youth had a certified HIV counselor conduct the testing. There was documented consent from each of the youth tested. There was documentation of pre/post-test counseling contained within each of the youth's IHCR. There were no youth requiring any internal alert. None of the youth consented to release of information to any other individuals. The program uses AIDS healthcare foundation to provide pre/post-test counseling, if needed. Five youth were interviewed, each agreed they can ask for a HIV/Aids test if they want.

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

Five youth individual healthcare records (IHCRs) were reviewed for sick call process. None of the five-youth presented with similar sick call complaints three or more times within a two-week period. One youth had a complaint which was severe in nature, where staff were unfamiliar. The one incident was treated as an emergency and an immediate referral was made to a licensed healthcare professional. Sick call request forms were reviewed, each were completed on a Sick Call Request form, which was filed with the progress notes in each of the youth's IHCR. The program has regular scheduled sick call hours posted. Sick call is provided to the youth seven days a week. The registered nurse (RN) on duty at time the Sick Call form is submitted provides sick call services. Non-healthcare care protocols are utilized for sick call when licensed nurses are not on-site. The back-up procedure for notification to the nurse is to contact the nurse by telephone.

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

Five youth individual healthcare records (IHCRs) were reviewed for sick call. Documentation reflected five of five youth reviewed completed a sick call request. In each case, documentation reflected the sick call was completed by the on-site registered nurse (RN). Sick Call forms and progress notes are documented in accordance with Health Services Rule. Sick calls were observed documented on the Sick Call Index. Sick calls are documented on the Sick Call Referrals Log. Documentation reflected five of five youth signatures or initials were documented on the sick call log at the time youth was seen. Each of the five youth IHCRs reflected the Sick Call Request form was filed with the progress notes. According to the written policy and procedures, youth are ensured privacy during sick call encounters, sick call availability and request forms are readily available to youth, and an exam table and equipment are utilized to perform sick call. Sick call was not observed during the annual compliance review. Five staff were interviewed, each staff stated the nurse conducts sick calls at the program.

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

The program does not use restricted housing; therefore, this indicator rates as non-applicable.

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

The program has a written policy and procedures outlining the process for episodic care and first aid. One of five youth medical records reviewed was applicable for episodic care. The progress notes for the applicable youth contained the following information: date and time, nature of the complaint, findings of person rendering care, treatment rendered, referral for off-site care, education/instruction to youth, plans for follow-up, alert, parental notification, and name and credentials of staff providing care. The instance of episodic care reviewed was documented by health care staff utilizing the subjective, objective, assessment, plan (SOAP) format. Emergency medical and dental care, including EMS services are available twenty-four hours a day. First aid kits are located in master control, medical, dorms, and vehicles. First aid kits were observed to be fully stocked with approved items. Medical staff reviews items in the first aid kits and restocks them as needed. The Episodic Care log documents all instances of first aid and emergency care. The Episodic Care Log was reviewed for the previous six months and compared with on/off-site events from youth records.

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

The program has two automated external defibrillator (AED) on-site, one located in the hall of master control and the other in medical. The batteries have an expiration date of March 2022 and the pads expire August 2019. The nurse demonstrated a complete test of the AED, including removing and replacing the battery. The program completed mock emergency medical drills quarterly on each shift. The mock emergency drills included cardiopulmonary resuscitation (CPR) and AED demonstration. The list of emergency numbers, to include the poison control center, are posted in medical department and the main room inaccessible to the youth. Documentation reflected all healthcare and supervisory level staff being appropriately trained on the administration of the epinephrine auto injector. Ten staff training records were reviewed and document the staff received training in first aid, CPR, and AED prior to access to the youth. Nursing staff was asked what the process is for conducting mock emergency medical drills, they replied; Drills are conducted for each shift, on a quarterly basis in a simulated manner which relates episodic care for first aid, or administration of CPR techniques, and emergency procedures for life threatening events. Five staff were interviewed, each agreed they are personally allowed to call 9-1-1 if a youth has a medical emergency.

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

One of five youth individual healthcare records (IHCR) reviewed was applicable for off-site care. Parental notification was documented in the youth's IHCR. A Summary of Off-Site Care forms was present in the records reviewed. The Designated Health Authority (DHA) reviewed and signed each form. Discharge information and instructions were filed in the applicable youth record. The youth required follow-up testing, referral, and or appointment. There was evidence with the youths IHCR where referrals were tracked, and youth was in receipt of appropriate, timely follow-up care as needed.

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

The program has a written policy and procedure ensuring all youth with a chronic illness receive regularly scheduled evaluations and necessary follow-up. Three of five youth reviewed individual healthcare records (IHCRs) were applicable for chronic illness. One youth IHCR reviewed was applicable for a communicable disease and two youth were taking prescribed medication on an on-going basis. Documentation reflected all three youth were classified with medical grades two to five. Two of the three applicable youth were placed on a chronic illness list. Documentation reflected two of the three youth were applicable for periodic evaluations. Both youth received periodic evaluations at no greater than three-month intervals. Documentation reflected all three youth received a specialized treatment plan. Periodic evaluations are tracked and documented in the youth's IHCR. There were no indications of lapsed or missed periodic evaluations. The problem list is updated in accordance with Health Services Rule 63-M. The program director was interviewed concerning the formalized procedure in place for healthcare staff to review important medical issues, he replied; there is a management meeting conducted weekly where the medical staff briefs on any medical issues or concerns on our youth. However, all medical issues in connection with direct health, moral and welfare of any youth are dealt with immediately and the proper authority (DHA), Department of Juvenile Justice, parents/guardians, commitment managers, are notified and briefed on all necessary treatment. The DHA was interviewed and identified reviewing the chronic log schedule is how he knows which youth have a chronic condition and when they receive a periodic evaluation as required.

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

The program has a written policy and procedures addressing medication verification. Three applicable youth individual healthcare records (IHCRs) were reviewed. Three of three youth were taking medication upon admission to the program. In all three IHCRs, prescription verification was noted in the chronological progress notes and the Designated Health Authority (DHA) was contacted and ordered the medications to be resumed.

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

The program has a written policy and procedures outlining medications prescriptions/orders. Three of five youth individual healthcare records (IHCRs) reviewed were applicable for medication prescriptions/orders. Documentation in all three IHCRs reflected a current, valid order for prescription medication. The documentation in all three IHCRs reviewed reflected youth were taking prescription medication prior to admission to the program. In each case, the medications for all three youth were continued upon admission to the program. None of the youth received over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET).

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

The program has a written policy and procedures outlining the storage of medication. All medications were stored in a separate, secured (locked) area inaccessible to youth. All non-controlled medications (prescribed and over-the-counter) are stored in a separate, secure, locked area inaccessible to youth. Narcotics and other controlled medication are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secured refrigerator, which is only used for medication. Syringes and sharps were observed to be secured. The medication cart was clean and well organized and is separate from youth specific medications. The program has an agreement with the on-site pharmacy consultant for the disposal and destruction of either discontinued or expired youth medications.

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

The program's nursing staff inventories all over-the-counter (OTC) medications at least weekly. A perpetual inventory is used for all controlled substances, with a shift-to-shift inventory process. Syringes and sharps and counted weekly, as well as, by using a perpetual inventory process. The program has a method in place for detecting and responding to inventory discrepancies. There is also a procedure in place for the disposal of narcotics and other controlled substances. Observations were made of counts being conducted by the nursing staff, and verification made of ending inventory numbers matching the count done. An inventory of three youth medications and three OTC medications was completed. No discrepancies were noted. Program inventories for the previous six months were reviewed, and no discrepancies were noted. In addition, three sharps were selected and inventoried and there were no discrepancies found.

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

The program has a written policy and procedures concerning medication management and controlled medications, to include the inventory of these medications. The procedure outlines the shift-to-shift procedure for medication inventory. Controlled medications are stored secure behind two locks, separated from other medications. The pharmacist consultant reviewed the controlled medications once each month with the nurse. Counts are conducted and documented for controlled substances. Supervisory level non-health care staff are trained in the delivery and oversight of medication self-administration and may perform these duties in the event nursing staff are not on-site. Observations was conducted of three randomly selected controlled medication counts by the nursing staff. Verification was made of medication counts matching the corresponding inventory numbers. A review of the controlled medication inventories for shift-to-shift counts for the previous six months was completed. The counts were documented as required.

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

A review of five youth individual healthcare records (IHCRs) and Facility Entry Physical Health Screening (FEPHS) forms were reviewed. Three of five youth IHCRs were applicable for completion of the Medication Administration Record (MAR). Each of the three applicable IHCRs contained a MAR, which included documentation of the youth's name, Department identification number, date of birth, allergies, precautions, medical grade, medical alerts, a current picture of the youth, and the name of the medication. All IHCRs reviewed found evidence the initial MAR matched the medication list. Each MAR indicates the youth received the medication as ordered. Each of the five youth IHCRs observed included documentation of medication start and stop dates. There were no lapses or errors for the three MARs reviewed. Documentation also found included nursing staff noting weekly side-effect monitoring on the MAR itself. The program requires any refusal of medication are documented on the MAR. Amy missed psychotropic medications are required to be reported to the Central Communications Center (CCC). A review of the progress notes and Authority for Evaluation and Treatment (AET) order section was completed to determine medication continuances, discontinuances, or changes.

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

Five youth individual healthcare records (IHCRs) were reviewed for medication administration by a licensed staff. None of the five youth reviewed required parenteral medication. For all youth, medication administration occurred as scheduled. A medication pass was observed during the annual compliance review. The working space was observed clean and organized. The nurse had control of the medication containers and medication cart. The process was structured for youth to approach the licensed staff person. The Five Rights of Medication Administration were verified for every youth, including a verification within the youths'

Medication Administration Record (MAR), and allergy and medical alert verification. The medical staff question each youth on a weekly basis concerning relevant side-effects and documents side-effect monitoring on the MAR for each youth receiving medications. Staff observe each youth making sure the medication is being swallowed. The program prohibits pre-pouring of prescription medications form original packaging and placed in another container for subsequent administration. Any youth refusal of medication is clearly documented on the MAR. Five youth were interviewed and all reported the nurse provides their medications. One youth also responded staff has provided medication. All interviewed youth reported staff escort them to the nurse's station when medication is administered.

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

The program's practice is for the nurses to dispense medication when on-site. The nurses' schedules are arranged so a nurse is on-site when medications are to be dispensed. However, there is a list of unlicensed staff authorized to supervise self-administration of medication which is noted on the Medication Administration Record (MAR). A review of training records confirms each staff were trained on assisting the youth with self-administrating of medications. None of the five reviewed youth individual healthcare records were applicable for medication having been administered by a non-licensed healthcare staff. Five youth were interviewed. All youth reported the nurse provides their medications. One youth also responded staff has provided medication. Five interviewed staff all report the nurse is responsible for administering youth medications.

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

The program has a comprehensive process in place for the monitoring of psychotropic medications to ensure the youths' safety. There were no standing orders, PRN orders, or emergency treatment orders for psychotropic medications. On a monthly basis, the psychiatrist and nursing staff document monitoring for Tardive Dyskinesia for all applicable psychotropics. Progress notes for youth individual healthcare records (IHCRs) were reviewed to ensure there was documented notification to all required parties when youth are admitted with psychotropic medication. Two of five youth IHCRs were applicable for psychotropic medication monitoring. In both records, the Designated Health Authority (DHA) and Designated Mental Health Authority (DMHA) were notified upon the youths' admission. The medications the youth were receiving were continued to be administered until an initial diagnostic psychiatric interview was conducted. The interviews were done within fourteen days of each youths' admission. Both youth received medication monitoring by the psychiatrist. A psychiatric referral was required and completed for the psychiatrist by the mental health staff person within twenty-four hours of the mental health evaluation. The psychiatrist made the determination of needed medications, and both youth received an initial diagnostic psychiatric interview within fourteen days from admission. For both youth, an in-depth psychiatric evaluation was completed within thirty days of admission and documented on the Department of Juvenile Justice (DJJ) form, Clinical

Psychotropic Progress Note (CPPN). The CPPN included the youth diagnosis, target symptoms for each medication, evaluation and description of effects of prescribed medication on target symptoms side effect monitoring, the youths' adherence to the medication regimen, recent laboratory findings to include the youth's height, weight, blood pressure, and serum drug levels. Telephone contact was documented for both youth regarding contact with their parent/guardian. The psychiatrist signed both CPPNs and included the date of signature. The psychiatrist and nursing staff have documentation of monitoring Tardive Dyskinesia on a monthly basis for the youth.

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

The program has infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, as per Occupational Safety Health Administration (OSHA) federal regulations and the Center for Disease Control (CDC) guidelines. The program's infection control procedures includes attention to the following: common infectious childhood diseases, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A-B-C and infectious diseases caused by blood-borne pathogens, outbreaks of pediculosis, Methicillin-Resistant Staphylococcus Aureus (MRSA), food-borne illnesses, bio-terrorist agents, chemical exposure, Hepatitis B immunization for staff, and access to protective equipment. The program provided documentation indicating universal precautions are followed by all staff. There have been no staff or youth who have experienced a facility occupational exposure requiring quarantining or hospitalization since the last annual compliance review.

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

Five youth individual healthcare records (IHCRs) were reviewed for inflection control education. There is evidence in each of the five IHCRs, youth received infection control training for required education, to include topics such as presentation of communicable diseases, and prevention of blood-borne pathogens. The program's comprehensive infection control education plan addresses pre-service and in-service training for all staff. Five pre-service and five in-service training records were reviewed. All ten-staff received training in infection control, as required.

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

The program has an exposure control plan which is written in accordance with the Occupational Safety Health Administration (OSHA) standards. The plan is available to all staff. The plan was reviewed and signed annually by the Executive Director. The exposure control plan included a risk assessment and methods of compliance, as well as a comprehensive process for needle

stick post-exposure evaluation. The program's administration establishes a separate record system, maintained for youth and employees who have experienced a facility/occupational exposure. Records are maintained confidentially for at least a ten-year period. There have been no staff or youth who have experienced a facility occupational exposure requiring quarantining or hospitalization since the last annual compliance review. The Executive Director was interviewed concerning the exposure control plan. He stated a copy of the plan is maintained in the central staff cabinet located on the main floor area. The plan is reviewed by management annually and also updated on an as needed basis in formation with OSHA standards, and AMIkids Hope Office Risk Management Unit.

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

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

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

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

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures which defines active supervision as being actively involved with the youth and positioning oneself in a location where one can see and talk with all youth within their grouping. The policy further indicates this will aid staff in the redirection of inappropriate behaviors. During the annual compliance review, positive interactions were observed between staff and youth. The program had a full schedule of activities planned for youth. The activity schedule was posted throughout program areas. Consistent application of the behavior management system was being demonstrated by staff. No youth were observed roaming free and without staff supervision. Youth were seen in classrooms, recreational activities, and groups. A direct care staff was interviewed regarding the procedure when a head count cannot be reconciled. The staff stated formal counts are done as required, and the supervisor will physically count the youth. In the event of a discrepancy, the youth are all instructed to come to the large common area and are physically counted again. If the search continues to not be accurate, a search for the missing youth will commence. Random staff were questioned, during the annual compliance review, regarding the number of youth under their supervision. All staff were able to give the accurate count. The program has a staff to youth ratio for daytime activities of one staff to ten youth. During sleep hours, the ratio is one staff to twelve youth. Observations made during the review period found the ratio was being maintained consistently.

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

The program has a behavior management system (BMS) which incorporates the Personal Growth Model. This model has three major components which are behavior modification, education, and treatment. The program's BMS has not been changed from the last annual compliance review. The plan has a detailed written description of the BMS strategies which is consistent with the principles of learning theory, to include a variety of rewards used by the program, appropriate consequences and sanctions used, and consequences which are applied immediately and are matched to the severity of the behavior. The application of rewards outnumbers the consequences in the program by at least four to one. The program provides opportunities for youth to earn privileges such as outings, token store, and participation in various activities. All appropriate parties were involved in the development, implementation, and on-going maintenance of the BMS. The program's BMS is clearly written and is posted within program areas. The written BMS includes promotion of youth rights, maintaining order and

security, opportunities for positive reinforcement, constructive disciplinary action, processes for explaining to youth the reason for any sanctions imposed and allowing youth the opportunity to explain their behavior, and discussing with them alternative acceptable behaviors. The program's BMS is also incorporated into the youth's individual behavior and treatment planning process. Each youth, upon admission, signs for and receives a student handbook which includes an orientation of the BMS, and program rules and expectations. The handbook explains the level system, which consists of a system of the following ranks: Recruit, Seaman, Second Mate, First Mate, Chief, and Ensign. Five interviewed youth were each able to explain the various levels within the BMS ranking system. All five youth were able to explain the various rewards and consequences the program offers. Example of rewards included things such as community outings, token store, movie time, video games, and earlier release dates. Five interviewed staff were able to summarize the program's BMS and could explain the program's system of rewards and consequences. Staff gave examples of rewards such as the token economy system. Community outings were also named as a reward, which may include, high school games, bowling, festivals and local fairs. All five staff stated nothing could be taken away from a youth as a consequence for negative behavior. The Executive Director was interviewed and stated each week a summary of each component of the Personal Growth Model is provided to the director for review. Scores from education, mental health, and program operations are included for the youth. There is also a weekly rank board which is posted in the large common area which displays each youth's current rank within the program.

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

The program has a written policy and procedure to include a process wherein staff explain to the youth the reason for any sanction imposed, and youth are given the opportunity to explain their behavior. Staff and youth discuss the behavior's impact on others as well as alternative acceptable behaviors. The program's policy indicates they do not utilize room restriction or controlled observation. The program's behavior management system does not promote punishment of youth by other youth, nor does it promote group punishment or encourage disciplinary confinement. The policy indicates they do not deny a youth basic services, such as meals, mental health services, physical exercise. The behavior management system (BMS) is not utilized to increase a youth's length of stay. A sample of job descriptions for staff positions were reviewed and found evidence the descriptions specified job functions which included incorporation of the BMS. 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. An interview with the Executive Director revealed all staff are trained in the program's BMS. In addition, all staff receive training in motivational interviewing techniques.

Staff are evaluated on an annual basis to ensure the fidelity. 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. Staff are trained to administer principles with the program's BMS during school as well. Five interviewed staff reported youth are informed of consequences and behaviors through verbal re-direction, treatment team meetings, behavior reports, and verbal conversations with them. All five staff reported supervisors provide them feedback on their implementation of the BMS through evaluations, daily contact and communication, staff meetings, and bi-weekly shift meetings. Five interviewed youth all denied youth are ever allowed to punish other youth. All five confirmed staff were consistent in the use of rewards. The five youth were asked to rate the program's BMS. One youth responded it was fair, and four youth reported the system was good.

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

The program has a written policy and procedures which ensure staff observe youth at least every ten minutes while the youth are in their sleeping quarters, and during sleep times. The program has a video surveillance system consisting of fifteen total cameras, all of which were reported to be operational. The cameras are located in various area of the program. The camera monitoring system is able to store video recordings up to forty-five days. Observations of video monitoring for the completion of ten-minute checks was conducted. A total of seven separate dates, to include second shift and a weekend day were reviewed to show consistency with observation checks completed at the program. Two of the seven dates observed were found to have discrepancies. On January 29, 2019 the video showed a check completed by staff of youth rooms at approximately 3:25 a.m., and the next room check was not completed until 3:43 a.m. This resulted in an eighteen-minute gap, in which a room check was not completed. In addition, on January 4, 2019, another gap in time between room observation checks was found between the time of 3:19 a.m. and 3:36 a.m. This resulted in a seventeen-minute gap, in which a room check was not completed. A review of the correlating room-check documentation forms did indicate, through documentation, the gap in times for these two periods. Staff had documented both checks as having been completed within every ten-minutes. This information was given to the program administration during the annual compliance review and was reported to the Central Communications Center (CCC) for falsification of documentation. The youth living area is one main hall way. There are no youth room doors. One staff is positioned at the end of each hall, with a third stationed in the middle. Staff were observed stopping and looking into youth rooms and documenting on the observation forms. The Director of Operations was interviewed and stated administrative staff have access to video monitoring on their assigned laptops and provide oversight of the fidelity of the checks being completed.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day.

The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.

The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is practicable after order has been restored.

The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.

The program has a written policy and procedures for census, counts, and tracking, to ensure youth are accounted for at all times through a system of physically counting the youth at various times throughout the day. Observations were made of counts being conducted during the annual compliance review. Youth are lined up and counted prior to movement throughout the program. A review of the program's master logbook found evidence counts were done at the beginning, middle, and end of each shift, after outdoor activities, when youth are off-center, and during emergency situations, if necessary. 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 escort, and the time in and out of the program. Samples of completed forms were observed to show consistency with the practice. Five interviewed staff were able to accurately discuss the process of completing headcounts. The staff reported in the event of a discrepancy, the supervisor would be notified. In the event the youth was searched for and not located, law enforcement may be contacted as well as the Central Communications Center (CCC).

5.06 Logbook Entries and Shift Report Review	Satisfactory Compliance

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

The program utilizes one master logbook for the chronological record of events, incidents, and activities. A review of logbooks for the previous six months was conducted. All logs were bound with numbered pages. The entries were made in ink with no erasures and white-out areas. Errors were seen struck through with a single line and dated and initialed. All entries included the date and time of the event, with the name of the staff and youth involved, a brief description of the event, and signature of staff making the entry. The program uses the logbook as the daily shift report as well. Each incoming staff review the previous shift information in the log and initial indicating their review. The executive director also signs the logbook daily indicating he reviewed the information. A review of logs found this system was done consistently. The logbook information also includes daily shift documentation of a facility security checklist, formal headcounts, and youth internal alert information. Perimeter checks are also captured for each

shift. Admissions and releases of youth were observed documented accordingly. A review of five reports made by the program to the Central Communications Center (CCC) found all five were documented in the logbook.

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

The program has a written policy and procedures in place to govern the control and usage of keys. The system includes key assignment including restrictions on usage, inventory and tracking of keys, secure storage, and procedures for missing or damaged keys. Observations of the program's key control process were made during the annual compliance review. Visitor keys were collected by staff prior to entering the secure area of the program. Visitor keys were taken and stored in a lock box at the front foyer area. Visitors were given a numbered chit in exchange for their key. Direct care staff obtain program keys using the following system: Upon arrival to work, the staff member's personal keys are taken by the shift supervisor and stored in a lock box within the Key Room. The Key Room was observed inaccessible to youth. The assigned duty keys are then given to the staff member, who returns them for their personal keys at the end of their shift. The collection and distribution of these keys was observed to be consistent. The program maintains a list of restricted and permanent issued keys. All staff, regardless of receiving permanent or temporary shift keys are responsible for placing their personal keys into the secured key box within the Key Room on an assigned number. A review of three random staff, which included one supervisory staff, was done to check for personal keys. All three staff checked did not have their personal keys on them, but had them stored within the key box as required. The Director of Operations was interviewed and stated the program has not had any incident of missing or lost keys within the past year. The shift supervisor was interviewed concerning the key inventory process. He stated the supervisor reviews the key log weekly to ensure staff are signing keys in and out, as required. In the event there are discrepancies, they are reported to the Director of Operations or other administrative staff. Observations of the keys was made during the annual compliance review. A sample of five randomly selected key ring sets were reviewed to ensure the number of keys matched the corresponding inventory form. Four of five sets matched the corresponding number of keys on each ring. One of the five sets, which was a set of case management keys, had two extra small keys attached to the ring. An interview with the therapeutic and case management director revealed these two extra keys were for two filing cabinets within their office. The program administration was notified of the discrepancy and instructed to revise the inventory form for this set of keys to ensure the number of keys correctly matched the number on the inventory. Five interviewed staff all were able to summarize the program's key control process. All five staff confirmed personal keys are kept secured while on duty.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program has a written policy and procedures in place for the prevention and introduction of contraband into the program. All youth are provided with student handbook and orientation information upon their admission to the program. The information provided outlines program rules and lists items considered to be contraband. A review of the list of items considered to be contraband included personal cell phones and/or equipment or electronic devices capable of taking pictures or video recordings, which are prohibited in the secure area. A review of five youth case management records found all five youth signed for receipt of this information upon their initial arrival to the program. The program’s policy for contraband incorporates searches of the physical plant, facility grounds, youth and staff, and incoming and outgoing youth mail. The program’s policy did not specifically address any employee who is found in possession of contraband would be subject to disciplinary action up to and including dismissal. The policy did address requirements for contacting law enforcement if any item found would be considered illegal. The Director of Operations was interviewed regarding contraband searches. Room search forms were provided to show examples of random room contraband searches conducted. The Director of Operations reported each shift performs random room searches and documents the information on the search form. Based on a review of the room search forms, there was no illegal contraband found documented. Items discovered and documented included things such as pens, rubber band, pencil, and water bottles. The forms included a section for disposition of items found. The completion of the disposition section was inconsistent and incomplete for the majority of the room search forms. A review of the program’s logbook found documentation of searches completed within the program. The program’s policy indicates any illegal contraband is to be turned over to law enforcement, and notification would be made to the Central Communications Center (CCC). This statement was also located at the top of the room search forms. The Executive Director was interviewed concerning contraband procedures. He indicated contraband is seized and placed in clear plastic bags or other suitable containers. Names of youth, and the date of the contraband seizure will be placed on the container, along with the name of the staff discovering the items. A contraband custody form will be filled out and placed in the container. Only items which will be returned at a later date will be used as evidence in disciplinary or criminal proceedings will be stored. All other items will be disposed of and the disposal method and date will be recorded on the form.

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

The program has a written policy and procedures regarding searches and full body visual searches. Each youth, upon admission, is provided a student handbook and undergoes an orientation process which consists of the search procedures within the program. All youth undergo a full body visual search upon arrival. A review of five case management records found evidence each youth signed for and received the search policy criteria. A review of the logbook found documentation of youth searches conducted. The program's procedure for clothed searches is outlined within their policy. Observations of searches were made during the annual compliance review. Youth were seen being searched prior to movement from one program area to another. During searches observed, youth were treated with dignity and respect to minimize stress and embarrassment. All searches were conducted by the appropriate number of staff and gender. Searches were thorough and conducted according to the program's policy and procedure with one exception being staff did not consistently have youth remove their shoes and socks for each search observed. Five staff were interviewed concerning youth searches. All staff reported searches of youth are done when there is any youth movement, classroom changes, visitation or home visits, and anytime a youth leaves and returns from off-campus. Five interviewed youth all stated searches occur when they return from off-campus activities, after outdoor activities, when items are believed to be missing, after visitation, after meals, and after work detail.

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

The program has four vehicles used to transport youth for off-campus activities. One vehicle was reported to be in the automotive shop undergoing repairs during the annual compliance review period and was therefore unable to be seen. The remaining three vehicles were observed and inspected for vehicles and maintenance requirements. The vehicles consisted of two vans and one sedan. All vehicles had received a documented annual safety inspection. The program also provided documentation of a vehicle preventive maintenance checklist which was completed by the automotive maintenance technician confirming inspection of areas such as oil and filter changes, tires, suspension inspection, inspection of instruments and controls, and inspection of seat belts. Documentation of these inspections were from November and December of 2018. All three vehicles were observed secured and parked in the front parking lot of the program. All had a fire extinguisher, approved first aid kit, seat belt cutter, and window punch. The two vans did not have the appropriate number of seat belts present. One van had three seatbelts which were not working properly. The other van was missing four seatbelts. Some working belts were pushed underneath the seats and were difficult to pull back through in

order to properly secure a passenger. Both vans had tears in seats and some seat springs were broken. One van had excess graffiti written on the overhead area within the vehicle. One van floor had rust in the floorboard which had resulted in a hole exposing the ground below approximately one inch wide and four inches in length. One van side passenger door was unable to be opened from the inside or outside, and the outside handle was broken, and it was missing the handle from the inside. Three interviewed staff reported everyone is required to wear seatbelts during transports. Three of five interviewed youth reported they wear seatbelts as required. Two of the five youth reported they do not consistently wear seatbelts during transports, stating some of the seatbelts do not work. The program administration was made aware of the unsatisfactory condition of the vehicles and the vans were ordered to be parked and not used for youth transports until further maintenance is completed. Prior to the end of the annual compliance review, the program obtained two new rental vans to be temporarily used for any youth transports. A random check of personal vehicles was completed and found all personal and program vehicles were secured as required.

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

The program has a written policy and procedures for the transportation of youth. The program's procedure provides the minimum ratio of one staff for every five youth during transportation. The policy further indicates youth and staff wear seat belts during transportation and shall not be attached to any part of the vehicle by any means, other than the proper use of a seat belt. Staff shall also not leave youth unsupervised in a vehicle. Staff are not authorized to transport youth in any personal vehicles, and youth are not permitted to drive the vehicles at any time. One staff of the same gender is required to be present for all transports, according to the program's policy. An inspection of the vehicles used to transport youth found they do not have or require a safety screen, as the program is a non-secure residential facility. A youth transport was unable to be observed during the annual compliance review. Three interviewed staff reported everyone is required to wear seatbelts during transports. Three of five interviewed youth reported they wear seatbelts as required. Two of the five youth reported they do not consistently wear seatbelts during transports, stating some of the seatbelts do not work. A shift supervisor was interviewed and stated transporters are provided a cellular phone by the direct care supervisor prior to transporting youth in the event of vehicle problems or emergencies. A review of five personnel records for staff authorized to provide transportation, found all had a current Florida driver's license. An interview with the program's human resources staff discovered all new hires are checked for a valid driver license. The program receives monthly monitoring from their home office through SAMBA Safety which monitors for any citations and driver restrictions. The human resources staff is made aware of any restrictions through electronic notification.

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

The program has a written policy and procedures which outlines the weekly safety and security audits for the program. The Director of Operations is responsible for conducting weekly security audits and safety inspections. Any corrective action and identification of deficiencies are documented on these forms. Observations of the completed weekly security audit forms were observed and found to be consistent with the program's policy. There were no deficiencies

noted. Verbal confirmation was also obtained with residential operations staff who receives the program's completed forms on a weekly basis. The residential operations staff reported the program has been consistent in providing the required information. The Executive Director was interviewed and stated all corrective action plans are developed, annotated, and tracked through to completion.

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

The program has a written policy and procedures addressing the issuance, inventory, and control of equipment and tools. The program's policy prohibits machetes, bowie knives, or other long blade knives. The policy also addresses procedures for missing or lost tools. 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. The process for disposing of dysfunctional tools was observed during the annual compliance review, as a hand squeegee was being inventoried and discovered broken. The maintenance manager disposed of the item and documented this on the Maintenance Daily Task Sheet. All maintenance tools were observed secured in the maintenance office and outside storage unit. These areas were secured and inaccessible to youth. All tools were inventoried daily by the maintenance manager. Documentation of daily inventory forms were observed. Tools were primarily stored using a shadow-board system. Not all maintenance tools located in the maintenance storage area were engraved with identifying marks. Tools are signed in and out as they are used and brought into the secure area. An inventory of all tools was completed. The items on the inventory form matched the items present. There were a few excess tools such as shovels and hoes which did not belong to the program. The maintenance manager reported these were his personal items. He was instructed any personal items or tools need to be removed from program areas. The maintenance manager prepared a maintenance bag, which contains various tools used primarily when completing tasks within the secure area. The bag is inventoried daily and signed in and out using a tool log. These items within the maintenance tool bag were engraved for identification. An interview with the maintenance manager revealed the items within the maintenance tool bag were the only ones permitted to enter the facility. Items such as brooms, mops, and mop buckets are stored in the patio storage, which is accessible by all direct care staff keys. The items are used by staff and youth when performing daily cleanup activities. These tools were all accounted for, based on the inventory form. The sign in and out log was also present for staff to document when these items leave and return to this storage area. Five in-service and five pre-service staff training records found evidence all staff are trained on tool usage. Five youth were interviewed concerning tool usage. No youth reported they use maintenance tools. All five reported they only utilize tools such as rakes, scrub brushes, mops, and brooms.

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

The program has a written policy and procedures in place concerning youth tool handling and supervision. The program reports they do not facilitate vocational activities involving tool usage on-site. Youth are primarily authorized tools to clean program areas. Five interviewed youth reported they only use tools such as scrub brushes, rakes, brooms, and mops. Observations

were made of these cleaning tools signed in and out of their secure storage area. Staff to youth ratio for projects involving tool usage is one staff to five youth. Observations were made during the annual compliance review of clean-up activities. Youth were observed using brooms and mops with staff providing direct supervision. Five interviewed staff all reported youth use mops and brooms. No staff reported youth utilize vocational or maintenance tools at the program. Some youth have received training to operate a lawnmower for grass cutting on the program grounds. Documentation of the completed safety training was observed for each of these youth. Risk assessments were also used for youth who participate in vocational or off-campus activities. An interview with the Director of Operations found the program had one youth who is eligible for participate in vocational training through an AMIkids day treatment program off-campus. Documentation of the risk assessment was observed to show the youth was eligible for the activity. The Director of Operations stated youth who are eligible to participate in vocational activities off-campus must meet qualifications such as age, education, maintenance of treatment and performance goals, and successfully pass the off-campus risk assessment criteria.

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 provides guidelines for repairmen and external contractors to include the following: tools are to be checked upon arrival and departure, tool restrictions are to be followed while in the facility, youth are restricted from work areas, and missing tool follow-up procedures. 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 forms were observed signed by the outside contractors and witnessed by the maintenance manager. The maintenance manager was interviewed and stated he meets with all outside contractors upon their arrival to discuss the guidelines and restrictions. The contractor’s vehicle keys are maintained secured in the maintenance office on an assigned key ring rack. The maintenance manager stated he shadows the contractors during the entire time they are in the program areas. A review of project invoices submitted to the program by the vendor matched the dates indicated on the Contractor Tool Inventory Verification forms.

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

The program has a Continuity of Operations Plan (COOP), as well as a written policy and procedures which discusses the conducting and frequency of fire, safety, and evacuation drills. The program is required to conduct fire drills monthly and on each shift. Safety and evacuation drills are to be completed quarterly for each shift. Fire evacuation and egress routes were observed posted throughout program areas. Drill documentation was maintained in a drill binder. A review of the drills found safety drills done for the previous two quarters of the annual compliance review period. One drill was completed for first shift, and one for second shift. The program did not have the safety drills for first and third shift for the first quarter, and second and third for the second quarter. Drill documentation listed participants and gave a brief description of the emergency and actions. The program also completed an evacuation drill on October 8, 2018. Fire drill documentation was reviewed. Fire drills were completed monthly and for all three shifts with no exceptions. The executive director was interviewed and stated drills are regularly

being conducted. A variety of different exercises are selected. Drill logs are located in the central staff cabinet on the main floor of the program. Five interviewed staff reported they have participated in the following drills over the past six months: weather, major disturbance, flooding, escape, fire, medical, and suicide response. All five interviewed youth responded they participate in fire drills and have been instructed as to what to do in the event of a fire. Five case management records were reviewed and found documentation where each of the five youth signed for and received emergency preparedness procedures upon admission to the program.

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

The program has a disaster and Continuity of Operations Plan (COOP) available for all staff to review. The Executive Director was interviewed and stated the COOP is available to all staff and is located in the central staff cabinet, on the main floor of the program. The COOP is reviewed annually and updated as needed. The last documented date of review was April 11, 2018. The plan addresses alternative housing plans approved by the Department of Juvenile Justice (DJJ) regional director. The program's disaster plan and COOP are coordinated into one plan. Documentation was present confirming the COOP was submitted to DJJ for approval March 29, 2018. The program's COOP contained annexes which were updated annually such as the delegation of authority, new cooperative agreements, vendor contact listing, emergency and staff contact numbers, and county cooperation checklist. The program maintains a supply of provisions and equipment required for continuous operation of services. The supply closet was secured and located in the large conference room. The program completed an evacuation drill on October 8, 2018. Drill documentation listed participants and gave a brief description of the emergency and actions.

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

The program has a written policy and procedures for the storage and inventory of flammable, poisonous, and toxic items and materials. The program maintains inventory forms for all areas used to store these items. The inventory is completed daily by the maintenance manager. Flammable items such as gasoline and propane were observed stored secured in a metal cabinet outside of the main building. The program did not have any gasoline stored in the containers within the metal storage cabinet during the time of the annual compliance review. The cabinet did contain Safety Data Sheets (SDS) for propane and gasoline, as required. Items in the flammable cabinet matched the inventory list. There were two other storage areas used to maintain chemicals and cleaning products, which were the patio storage and bulk storage units. These areas were also observed secured and inaccessible to youth. The bulk storage unit had a limited supply of chemicals, but there was no SDS present for this storage area. In addition, a bag of fire ant killer was present, but the item was not listed on the bulk storage inventory form. The patio storage unit was observed. This storage unit included an SDS for all items present, with the following exceptions: roach and ant killer, deodorizer, and glass cleaner. In addition, the inventory for the patio storage matched all items present with the exception of four bottles of

hand soap, in which the inventory read there were none. Prior to the end of the annual compliance review, the maintenance manager revised the inventory forms and printed updated SDS for items which did not have them. The maintenance manager, program manager, and executive director are the only staff reported to have access to the bulk storage and flammable storage area. The patio storage area is reportedly accessed by all staff, to include the direct care staff, as this area was used to maintain a supply of cleaning products and laundry detergent used within the secure area and youth living areas.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program shall maintain strict control of flammable, poisonous, and toxic items and materials. *Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.*	

The program has a written policy and procedures concerning youth handling and supervision of flammable, poisonous, toxic items, and materials. The program maintains control of these items through storage outside of the secure area. The storage closets and cabinets were observed locked and 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. No items were observed out and accessible to youth. The program's policy prohibits youth from cleaning, handling, or disposing of any bio-hazardous material, bodily fluids, or human waste. Youth also are prohibited from handling or cleaning up dangerous or hazardous chemicals. Five youth were interviewed and asked if they use or handle any chemicals or cleaning products. All five youth reported they do not use any of these items.

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

The program has a written policy and procedures for the disposal of all flammable, toxic, caustic, and poisonous items. The maintenance manager is primarily responsible for the disposal of these materials. The maintenance manager was interviewed and reported disposal is completed by the process according to the Safety Data Sheets (SDS). In the event toxic chemicals or materials are needed to be disposed of, it will be according to the SDS, as well as through notification of the fire marshal, and naval base officials in which the program is located. The maintenance manager reported they historically have not had many incidents and need of disposing chemicals, and therefore did not have a current log of any disposals during the scope of the annual compliance review. An interview with the program's registered nurse (RN) revealed any bio-hazardous waste is disposed of in a container marked as 'bio-hazardous waste material'. This container was observed in the medical department. The RN stated the program has 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 secured and inaccessible to youth. The program prepares no meals on-site, and therefore has no kitchen or grease traps or containers. An

interview with direct care staff member revealed all dirty mop water is disposed of in mop sinks and drains. In the event of a chemical spill, the material is cleaned according to the SDS, using proper safety materials and clothing.

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

The activity schedule was observed posted throughout program areas. The schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities for youth. A review of the program's logbook revealed activities are documented confirming the program's adherence to the schedule. The program has a written policy and procedures which discusses activities provided based on the needs and developmental levels of the youth. Youth are encouraged to explore various interests such as athletics, recreation, vocational activities, and education. Activities provided promote social and cognitive skill development, creativity, and teamwork. To prevent youth illness or physical injury due to weather related conditions, the Director of Operations reported the program operates on a weather system alert process in cooperation with the naval base flag system. The base officials will fly certain color flags and follow-up with announcements alerting all military personnel, as well as the residential program, of potential hazardous weather conditions to caution people when participating in outdoor activities. Black colored flags represent no outside activity, yellow means caution. A red flag represents water breaks are required every fifteen minutes; and green flags represent normal conditions are present. A review of the provider's contractual agreement found the program is required to have a recreational therapist. The program reported their recreational therapist was vacated a week prior to the annual compliance review. The program reported they are currently in the process of hiring for this position. The program has formal processes in place to promote constructive input from youth. Program staff facilitate multiple group meetings with the youth to discuss program issues. Youth also are provided request to speak forms in order to discuss issues directly with staff from administration, mental health, education, or case management. All five interviewed youth reported they participate in at least one hour a day of physical and leisure activities. They stated they participate in activities such as basketball, football, soccer, and running. Five interviewed staff all responded similarly, stating youth are afforded recreational time to participate in various activities, to include gardening, arts and crafts, and sports.

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

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

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

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

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

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

The program has a written policy and procedures in place concerning the elements of the water safety plan, staff training, and requirements for a swim test. The policy requires the program to implement a safety plan to address youth risk determination, the type of water the activity to be held, water conditions, lifeguard to youth ratio, other staff supervision, and safety equipment needed. The policy further indicated additional staff supervision is required to ensure youth safety during water-related activities. A minimum ratio of one staff to five youth is required. AMIkids also utilizes a Water Safety Standards packet for youth water-related activities. The standards consist of procedures for swim testing youth and developing a water safety plan for water-related activities. The program provided examples of this documentation from the May 2018 Summer Challenge Event Travel Itinerary. The documentation included Youth Aquatic Skills Validation Forms for youth participating in swimming events. The form serves as the result of each youths' swim test and denotes the aquatic skills level of each youth. The itinerary also included the youth risk assessment and eligibility, staff supervising certifications, a trip checklist, trip budget, and emergency plan. Based on a review of the documentation provided for the May 2018 trip taken, the program was within the ratio of the one staff to five youth requirement. Risk assessments are completed for each youth prior to participating in any off-campus event, to include water-related activities. The program had a designated lifeguard, who after review of their personnel records, was found to be a certified as a lifeguard, in cardiopulmonary resuscitation (CPR), and first aid. In addition, five pre-service and five in-service staff training

records found evidence all staff have been certified in CPR, first aid, and automated external defibrillator (AED). The program provided documentation of youth swim tests conducted on two separate dates in August 2018. The program reported the youth are swim tested at Dive Pros located in the Pensacola area. The program had no attached water safety plans for these swim tests conducted in August. The program was advised all swim tests are considered water-related activities and must include a water safety plan addressing all requirements within policy. Four of five interviewed youth reported they have not participated in any water-related activities at the program. One youth confirmed to having taken a swim test.

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

The program has a written policy and procedure concerning visitation and communication for youth. Upon admission, each youth is provided the program's visitation policy and guidelines. The program's visitation policy also indicated consideration for requests of alternative visitation arrangements with parents/legal guardians, if needed. Five of five youth case management records reviewed found evidence each youth signed for and received information concerning visitation, telephone, and mail procedures upon arrival. The program posted their visitation schedule and rules throughout program areas, to include the front door of the facility. 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 student handbook which indicate youth rights and include each youth rights to visitation, mail and telephone access. Five interviewed youth all reported they have been given opportunities to communicate with their family members by mail, telephone, or at visitation.

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

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

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

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

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

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

Program Name: Escambia Boys Base
Provider Name: AMIKids, Inc.
Location: Escambia County / Circuit 1
Review Date(s): January 29 - February 1, 2019

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	5.10 Vehicles and Maintenance
5.22 Elements of the Water Safety Plan, Staff Training and Swim Test*	