STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Fort Myers Youth Acadmey

TrueCore Behavioral Solutions, LLC
(Contract Provider)
2215 Ortiz Avenue
Fort Myers, Florida 33905

Review Date(s): September 17-20, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Marissa Stress, Office of Program Accountability, Lead Reviewer ([Standard 1])
Teves Bush, Office of Program Accountability, Regional Monitor (Standard 5)
Christine Calvert, Office of Program Accountability, Regional Monitor (Standard 3)
Joey Nice, DJJ Office of Education, Education Coordinator (Standard 2)
Maryann Sanders, Office of Program Accountability, Deputy Regional Supervisor (Standard 4)

Program Name: Fort Myers Youth Academy	MQI Program Code: 1292
Provider Name: TrueCore Behavioral Solutions, LLC	Contract Number: 10117
Location: Lee County / Circuit 20	Number of Beds: 28
Review Date(s): September 17-20, 2019	Lead Reviewer Code: 178

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.20 Recreation and Leisure Activities	1.10 Delinquency Intervention and Facilitator Training
5.13 Tool Inventory and Mangement	

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	Failed
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Limited

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Fort Myers Youth Academy is a twenty-eight bed, non-secure residential program, for fourteen to eighteen-year old males, located in Fort Myers, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides services to youth committed by the juvenile criminal court who are in need of residential substance abuse treatment overlay services (SAOS), including substance abuse assessment, treatment, and relapse prevention for youth who abuse substances. Youth receive daily substance abuse treatment within a general offender correctional setting. The program's services address the criminogenic risk factors, according to the youth's needs and risks. In addition, the program is contracted to provide each youth with Thinking for a Change (T4C), Impact of Crime (IOC), restorative justice programming, Living in Balance, Pathways to Self-Discovery and Change, and Seeking Safety. The program also provides gender-specific services through Young Men's Work group. Additional treatment services provided include individual groups, recreational, and family therapy. Program management is comprised of a facility administrator (FA), assistant facility administrator (AFA), a director of clinical services, and a health services administrator. Case management services are provided by the case management staff and transition specialist. Mental health staff at the program includes a licensed designated mental health clinician authority/director of clinical services, one full time licensed therapist, and three master's-level therapists. The program's licensed therapist position has been vacant since August 22, 2019; however, the program has scheduled and completed interviews for potential candidates. The program subcontracts services for a licensed psychiatrist, certified behavior analyst, and certified addiction specialist. Medical services are offered seven days a week and are provided by the health services administrator and three registered nurses. During the time of the annual compliance review, the FA reported one of the registered nurses resigned September 13, 2019. Educational services are provided by the Lee County School District, on a year-round basis, with a regular mainstream school curriculum for course credit. The layout of the program includes two buildings and three portable units. The administration area has offices for the leadership team. There is one dormitory for youth housing, a multipurpose area, school area, kitchen, laundry area, and dining area. The program has thirty-one cameras. At the time of the annual compliance review, all cameras were reported to be operational. At the time of the annual compliance review, the program had eleven vacancies including one licensed mental health professional, one recreational therapist, one registered nurse, one physical plant manager, one psychologist, case manager, three youth specialists, and two staff mentors. However, at the time of the annual compliance review, the program's designated mental health clinician authority reported the psychologist position was vacant and the corporate office was working to finalize a new independent contractor agreement with a new psychologist.

Strengths and Innovative Approaches

- The program has participated in Habitat for Humanity projects as part of restorative justice programming efforts.

Standard 1: Management Accountability

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

The program maintains a written policy and procedures ensuring initial background screenings are conducted on all newly hired employees and volunteers. The program had fourteen newly hired staff since the last annual compliance review. There were also six contracted staff and one volunteer applicable for an initial background screening. Reviewed documentation supported the fourteen newly hired staff, six contracted staff, and one volunteer received background screenings completed by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each individual's date of hire and/or contact with youth or access to confidential information. Each newly hired staff's criminal history, Staff Verification System (SVS) module, Florida Department of Law Enforcement (FDLE), and the Department's Central Communications Center (CCC) Person Involvement Report were reviewed. There were no staff which required exemptions. Each newly hired staff, contracted staff, and volunteer was added to the Clearinghouse roster and none were applicable for breaks in service. Each direct care staff hired is required to complete a pre-employment assessment and must receive a passing score. The program had six direct staff hired who required a pre-employment assessment. Reviewed documentation found a pre-employment assessment was completed by each of the six newly hired direct care staff and a copy of the passing score was maintained in each staff's personnel record. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to BSU on January 23, 2019, along with the school board's annual screening which was submitted to BSU on December 4, 2018, meeting the annual requirement.

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 maintains a written policy and procedures ensuring the background rescreening process for staff every five years based upon their original date of hire. Rescreening documentation must be submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten days prior to the staff's five-year anniversary date. The program's human resource manager tracks the five-year anniversary of hire dates and processes the five-year rescreenings for all staff. Five-year rescreenings shall not be completed more than twelve months prior to the staff's anniversary date and at least ten business days

prior to the anniversary date. The program had two staff eligible for five-year rescreening. Reviewed documentation found one staff's five-year rescreening was completed and submitted to the Department's BSU/Clearing House Unit at least ten business days prior to their five-year anniversary date. One staff's five-year rescreening was completed and submitted to the Department's BSU/Clearinghouse five days after the five-year anniversary date. Reviewed documentation from human resources supported the staff was put on no contact with youth until the staff's background screen cleared. Reviewed documentation supported there were no volunteers or mentors applicable for a five-year rescreening.

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

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

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

The program maintains a written policy and procedures ensuring an environment free of abuse and neglect in which youth and staff feel safe and secure. The policy reflects youth and staff have unhindered access to reporting alleged abuse to the Florida Abuse Hotline. The policy outlines the reporting procedures for staff to follow when a youth would like to make an abuse call. Additionally, the program maintains an employee handbook which outlines the program's code of conduct. All staff are required to sign and acknowledge receipt of the employee handbook and code of conduct which outlines the grievance policies and their understanding of the program's code of conduct. A review of five personnel records found each record contained documentation of acknowledgement, receipt, and review of the program's code of conduct. Observations conducted during the annual compliance review found postings of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) throughout. The living module has a telephone which allows the youth to have direct access to the Florida Abuse Hotline. Observations during the physical plant tour found the telephone was currently working on the module. The youth have unhindered access to the Florida Abuse Hotline and CCC, for youth who are eighteen years of age. The program's current practice is once the youth requests to make an abuse call, the youth is instructed to pick up the telephone in the living module which has a direct access to the Florida Abuse Hotline. The youth can also be taken directly to

the administration building or the case manager or therapist's office to place the call. If a youth wishes to make a CCC call, they will notify the youth care worker who will contact the shift supervisor and/or youth mentor on duty to request the call be made. The shift supervisor and/or youth mentor will take the youth to the administration building to place the call. The program's policy also requires all staff to place abuse calls to the Florida Abuse Hotline if an allegation is suspected and a youth refuses to make the call. All allegations of abuse or neglect, as well as CCC reports are logged and maintained in the program's logbook. Abuse and CCC calls are reviewed in morning management meetings. The program completed a Trauma Responsive and Caring Environment (TRACE) assessment on April 9, 2019. Five randomly selected staff were interviewed. Each interviewed staff was able to describe the program's abuse and CCC reporting process. Each staff stated youth have unrestricted access to the Florida Abuse Hotline and Department's CCC. Four out of five interviewed staff denied observing a coworker use profanity, using threats, intimidation, or humiliation when interacting with youth. One staff reported co-workers do curse on occasion but not directly at youth. Five youth were interviewed, and each youth reported they are aware of the abuse reporting process. Three youth reported never being denied access to contacting the Florida Abuse Hotline or the Department's CCC. Two youth reported never needing to have placed an abuse call. Each interviewed youth reported they always feel safe in the program and have never been denied any basic rights. Each interviewed youth described the staff as respectful. One youth reported staff never curse, three youth stated staff curse occasionally, and one youth reported staff curse often. None of the youth reported staff curse directly at them. A review of all incidents since the last annual compliance review found there was one incident which involved a complaint against staff for physical abuse which was found to be unsubstantiated. The Florida Abuse Hotline and Department's CCC were notified, as required. The facility administrator (FA) was interviewed and reported if an allegation is made against staff, the staff is immediately placed on no youth contact and an internal investigation is conducted. Corrective action may include oral warnings, written disciplinary actions, suspension, and up to termination. The program also follows all recommendations of the Department's investigation.

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 maintains a written policy and procedures ensuring management takes immediate action to address incidents of physical, psychological, and emotional abuse. Staff are placed on no contact with youth until an internal investigation can be completed. Corrective action may include oral warnings, written disciplinary actions, suspension, and/or termination for any substantiated incidents. An interview with the facility administrator (FA) confirmed this practice. A review of all incidents since the last annual compliance review found one incident which involved a complaint against staff for physical abuse. The staff was immediately placed on no youth contact until the report was found to be unsubstantiated. Reviewed documentation found no further action was needed.

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

The program maintains a written policy and procedures ensuring the program reports incidents to the Department's Central Communications Center (CCC) within the required timeframe. The program had fourteen reportable incidents to the CCC in the last six months, of which five were reviewed. Documentation confirmed all five incidents were reported to the CCC within the mandatory two-hour time frame. The program maintains monthly logbooks for recording reports to the CCC. Each reviewed incident was documented in the monthly shift logbooks. A review of internal incidents for the past six months showed there were no incidents which should have been reported to the CCC but were not. The program's facility administrator (FA) stated if a youth believes they have been abused or neglected, they are given unrestricted access to the Florida Abuse Hotline or the CCC, if eighteen years old. If the youth refuses to make an abuse call, the staff is responsible for making the call as they are mandated reporters. The program has experienced a decrease in the number of reportable incidents to the CCC in comparison to the last annual compliance review.

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

The program maintains a written policy and procedures, as well as written plan, ensuring the utilization of Protective Action Response (PAR) techniques. All direct care staff shall be trained in PAR. A PAR report shall be completed any time a PAR incident occurs. PAR reports shall include statements by everyone involved, a review by a PAR certified instructor/supervisory staff, post-PAR interview, and a review of the PAR incident report by facility administrator or designee within seventy-two hours of the incident. The program's PAR plan was approved by the Department's Office of Staff and Development and Training on December 21, 2018. The program had thirty-one PAR reports completed within the last six months, of which five reports were reviewed. Each report reflected documentation showing each report included a review by a PAR-certified instructor and was processed within the seventy-two-hour time frame by all required parties. Reviewed documentation showed each record documented a post-PAR interview conducted within thirty minutes of the incident. A review of the PAR incident reports and comments by the facility administrator (FA) or designee within seventy-two hours of the incident, was found in each PAR report. Each reviewed report included statements from all parties involved. None of the reviewed reports required a PAR medical review or use of the Mechanical Restraint Supervision Log. Documentation confirmed each report was processed by a supervisor and a PAR instructor to determine if use of force was consistent with the policy in each PAR report. None of the reviewed reports mandated a report to the Department's Central Communications Center (CCC), and there was no documentation to support any involved youth made a report to the Florida Abuse Hotline. The program maintains a PAR binder which contains all PAR reports and PAR monthly summary reports, which are submitted to the Department The program's PAR rate during the annual compliance review period was 4.56

which is above the statewide residential PAR rate of 1.59. The program has experienced an increase in PARs since the last annual compliance review. An informal interview was conducted with the compliance manager. The compliance manager attributes the PAR increase to the increase of aggressive youth behavior at the program within the last six months. The compliance manager stated all staff are trained to always use verbal interventions as the primary method to handle difficult situations with youth. The FA reported additional treatment teams and interventions have been added, as needed, to help some of the more aggressive youth in the program as well.

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

The program maintains a written policy and procedures ensuring a plan for pre-service training. The program maintains a pre-service training plan and calendar for all new staff which was submitted to the Department's Office of Staff Development and Training on January 10, 2019 and signed and approved on January 16, 2019. Pre-service training is provided through a combination of instructor-led, web-based courses, and on the job training. Five staff training records were reviewed for pre-service training, of which two were supervisory training records. All reviewed records reflected each staff completed the certification process within 180 days of hire and completed all required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA), and active shooter training prior to having any contact with youth. All five staff training records reviewed showed documentation to support each staff exceed the required 120 hours of pre-service training. The contract requires all direct care staff to complete 129 hours of training within the first thirty days of employment. Reviewed documentation supported each reviewed staff training record found documentation to validate staff exceed 129 hours of training within the first thirty days of hire. Documentation showed all training was delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro). There were no additional training requirements for staff as documented in the provider's contract. All floor staff, inclusive of supervisory staff, are considered direct care staff and are counted for in the staff-to-youth ratio.

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

The program maintains a written policy and procedures ensuring in-service training is conducted annually. An in-service training plan was submitted to the Department's Office of Staff Development and Training on January 10, 2019 and signed and approved on January 16, 2019. Five staff training records were reviewed of which one was a supervisory staff training record for in-service training. The program only has three supervisor positions filled of which one was applicable for in service training requirements. Each reviewed staff training record documented each staff exceeded the twenty-four hours of in-service training requirements. Each staff had

current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff also completed training in professionalism and ethics, including standards of conduct, active shooter training, as well as six hours of suicide prevention. One supervisor training record was reviewed for completion of eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, communications skills, and fiscal. Reviewed documentation supported the supervisor training record contained the required eight hours of supervisory training. All trainings were conducted by certified trainers and documented in the Department's Learning System (SkillPro). The program maintains an annual training calendar which is updated to reflect any changes. The are no additional training requirements required under the program's contract. All floor staff, inclusive of supervisory staff, are considered direct care staff and are counted for in the staff-to-youth ratio.

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 maintains a written policy and procedures ensuring there is a grievance process. Staff must adhere to a formal and informal grievance process. Youth are given an explanation of the grievance process during admission and orientation into the program. The program maintains a written training plan for all pre-service training which includes the grievance process and procedures. Five pre-service training records were reviewed for grievance training. Each reviewed record contained documentation to validate each staff member was trained on the grievance process. The program's grievance process outlines an informal, formal, and appeal phase for each youth with designated seventy-two-hour time frames for each phase to provide feedback to the youth to rectify the situation except for the informal phase. All informal grievances must be responded to within twenty-four hours by the grievance officer which is the assistant facility administrator (AFA). The program uses "Let's Talk" forms prior to filing a formal grievance. "Let's Talk" forms allow youth to voice objections and informally file an issue or compliant prior to filing a formal grievance. Observations during the physical plant tour during the annual compliance review found "Let's Talk" forms and grievance forms were available to youth on the module and multi-purpose room. The program maintains a centralized binder of "Let's Talk" and grievance forms for at least twelve months. An interview with the facility administrator (FA) confirmed the program's grievance policy and procedures. There were thirty-nine total grievances filed in the last twelve months, of which five were reviewed. A review of five grievances revealed each grievance was resolved at the formal level and within the required seventy-two-hour time frame. Each grievance showed documentation of youth participation, supervisory oversight, and final outcomes. None of the reviewed grievances required an appeal. Documentation revealed the grievance forms were consistently filled out completely. Five staff interviews were conducted of which each staff reported knowledge of the grievance process. Each of the five interviewed youth stated they were aware of the grievance process. Four of five interviewed youth reported they could request assistance in filling out the grievance. One youth reported not knowing youth could request assistance filling out a grievance. One of five youth interviewed knew there were timeframes for the grievance process. Four interviewed youth did not know there were timeframes for the grievance process.

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

The program maintains a written policy and procedures ensuring youth are provided delinquency interventions through evidence-based principles. A review of the program's contract and an interview with the facility administrator (FA) confirmed the program identified Life skills Training (LST) and Thinking for a Change (T4C) as the evidence-based delinquency intervention programs. A review of the program's activity schedule identified LST and T4C are each scheduled for one hour, twice a week, along with other structured activities. However, observations during the annual compliance review and an interview with the FA confirmed the program has not conducted a T4C group since March 18, 2019. The program has one trained T4C facilitator who transferred to the night shift in March 2019; therefore, no groups have been conducted since March 2019. Delinquency intervention groups are facilitated by case managers or youth care workers (YCWs). A review of records for staff who facilitated the groups found the appropriate trainings in each applicable intervention were completed and each staff had the applicable educational background for the group practices. An interview with the facility administrator (FA) confirmed the program considers staff's intervention training, education, and work experience to determine which staff deliver the delinquency intervention services. A review of group sign-in sheets validated LST groups were held, as required, with minimal interference and T4C groups were not held, as required. A review of five youth records and group sign-in sheets confirmed each youth received LST delinquency service interventions, and the intervention service goals were included as part of their individualized performance plans. An informal interview with the clinical director confirmed LST and T4C are the evidence-based interventions which are implemented in the program to address the priority needs of youth.

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

The program maintains a written policy and procedures ensuring youth receive life and social skills training. The program's policy ensures the youth receive life and social skills training to include decision making, communication, interpersonal relationships and interaction, non-violent conflict resolution, anger management, critical thinking, and problem solving. A review of the program's contract confirmed the program identified Teen Relationships, Controlling Ourselves, Don't Let Your Emotions Run Your Life, and Living in Balance as the life and social skills curriculums. A review of the program's activity schedule and documentation of group sign-in sheets confirmed youth received these services and participated in groups. A review of the staff who facilitate the groups validated they were trained to deliver the applicable curricula. An interview with the facility administrator (FA) confirmed the program considers staff's intervention training, education, and work experience to determine which staff deliver the life and social skills groups to the youth. Five randomly selected youth were interviewed. Each interviewed youth indicated they participate in groups and learn coping skills, how to stay drug free, stress management, and anger management skills. An informal interview with the clinical director confirmed youth are provided opportunities to learn decision making, communication, conflict

resolution, coping, and problem-solving skills. Youth are given the opportunity to practice these skills in groups through various role play scenarios.

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 maintains a written policy and procedures ensuring youth are provided opportunities for activities or instruction to increase youth awareness and empathy for crime victims and survivors. A review of the program's contract identifies the program utilizes the Impact of Crime (IOC) curriculum and community service projects to facilitate restorative justice programming. The IOC curriculum includes victim impact, personal accountability, consequences of actions, introduction to harm, managing conflict, effects of crime, and the road to reparation. A review of the program's daily activity schedule showed IOC groups are scheduled for one hour, twice a week. A review of group sign-in sheets validated groups were held according to the dates on the activity schedule. A review of staff training records confirmed staff facilitators of IOC completed IOC training prior to facilitating groups. Documentation of sign-in sheets and records, along with staff interviews, confirmed the program utilizes guest speakers to share personal stories to help teach youth about victim impact and personal accountability. An interview with the facility administrator (FA) was conducted. The FA confirmed youth participate in IOC and community service projects as part of the program's restorative justice practice. Youth are also encouraged to participate in Habitat for Humanity projects and campus cleanup projects. A review of five youth case management records and sign-in sheets found four youth had restorative justice programming outlined in the individual performance plan. One youth had been recently admitted into the program and not yet been added to an IOC group.

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

The program maintains a written policy and procedures encouraging youth to participate in gender-specific programming. The program provides delinquency interventions and treatment services which are gender specific and focus on preparing youth to live responsible in the community upon release. A review of the provider's contract identified the program utilizes the Young Men's Work group for gender-specific programming. The Young Men's Work group is a group for males ages fourteen to nineteen. The group is designed to teach young men to work together to solve problems without violence. An interview with the facility administrator (FA) was conducted. The FA reported the Young Men's Work group also helps the youth look at the underlying messages society gives adolescent males about what it means to be a man. Hand-outs, videos, and group discussions are all utilized to help instruct youth on gender-specific issues. All groups are facilitated by a trained master's level or licensed mental health care professional. A review of the program's daily schedule indicated the Young Men's Work groups is scheduled twice a week for one hour. Observations during the annual compliance review confirmed the Young Men's Work group was conducted at the scheduled time on the daily schedule and the therapist facilitated the curriculum, as required. A review of five youth case

management records confirmed youth were participating in the group. Five randomly selected youth were interviewed. Each interviewed youth reported participating in gender-specific groups. An interview with the clinical director confirmed each youth participates in Young Men's Work group while at the program.

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 maintains a written policy and procedures ensuring alerts are entered in the Department's Juvenile Justice Information System (JJIS) and maintained in the program's internal alert system. Critical and special alerts are reviewed, updated, and responded to appropriately. An informal interview with the facility administrator (FA) confirmed alerts are entered in JJIS. The FA also confirmed alerts are entered and verified by medical, mental health, case management, substance abuse, and administration staff. Each day, administration and youth mentors/shift supervisors review JJIS alert reports and internal alerts during the morning management meeting and discuss with all staff at each shift meeting. Any new or changed alert is also discussed in treatment team meetings. A hard copy of the alerts is always maintained with the youth mentor/shift supervisor. The program's internal alerts are also maintained in the program's shift logbook, daily, on each shift. A current alert list is maintained in the operations and administration building, as well as in the kitchen. The program maintains an alert board in the administration area and a review of the alert board found it to be maintained and updated. A review of five youth records for case management, medical, mental health, and substance abuse alerts found documentation reflecting each record was applicable for alerts. Each record had documentation which supported the appropriate alerts were entered into JJIS and the program's internal alert system. A review of each record found evidence supporting each alert was entered in the program's daily shift logbook. Each record found evidence supporting the alerts were verified and upgraded, as needed. A review of the JJIS Alert List found no issues or discrepancies affecting classification. An interview with the FA confirmed only a licensed mental health staff may remove or downgrade a mental health alert, only a licensed medical staff may remove or downgrade a medical alert, and only facility administration may remove or downgrade a security alert. Five randomly selected staff were interviewed, and each reported they are made aware of alerts during daily morning management meetings and shift briefings. Staff also reported alerts are also documented in the logbook.

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 a written policy and procedures ensuring the maintenance, creation, and storage of individual healthcare, mental health, substance abuse, and case management records for each youth. The program maintains individual, color coded, hardbound binders for case management, healthcare, and mental health and substance abuse records. Observations of the records found each marked "confidential" and secured in file cabinets in assigned offices not accessible to youth, when not being used. Observations of the records showed each had the required documentation on the spine and the front of the binder, to include the youth's name, date of birth, county of residence, date of admission, committing offense, and the Department identification number (DJJID). Reviewed records showed all of the most recent information in chronological order. Documents were organized into required sections and information was separated into designated sections with tabs for legal, demographic, case management with treatment plan and interventions, and correspondence, along with a miscellaneous tab.

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

The program maintains a written policy and procedures ensuring there is a process for youth to provide constructive feedback. The program maintains a youth advisory board comprised of youth enrolled in the program, giving youth the opportunity to have verbal contact with the program's administration regarding program operational concerns, complaints, and/or suggestions. Additionally, the program utilizes "Let's Talk" forms, which gives each youth an opportunity to address both positive and negative issues. The youth advisory board meets at least once a month under the supervision of the assistant facility administrator (AFA). Reviewed documentation revealed meetings were held at least once a month. Each meeting followed an individual agenda which addressed each request or complaint accordingly, either during the following month's youth advisory meeting or with program leadership. The youth also have daily informal meetings with staff mentors and the AFA to discuss "Let's Talk" forms and voice any other concerns which may arise. Five randomly selected youth were interviewed, and each confirmed youth can provide input and suggestions about the program during daily community meetings. An informal interview was conducted with the facility administrator (FA) in which the FA stated youth surveys are given to youth quarterly throughout the program through survey monkey in an effort to obtain additional feedback beyond the youth advisory board and daily meetings.

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

The program maintains a policy and procedures ensuring the program has an advisory board which meets quarterly. The program maintains a list of community advisory board members from the school board, law enforcement officials, community partners, faith-based organizations,

a local family reunification and mentoring agency, judiciary, business community, victim advocacy/victim services community representatives, and parents/guardians of former/present residents. Reviewed documentation for the last twelve months reflected the program's community advisory board met at least quarterly with one exception. There was no scheduled meeting for the January to March 2019 timeframe. An interview with the facility administrator (FA) indicated the program's administration was in transition and the meeting was overlooked. There was clear documentation to support the program made attempts to schedule meeting dates and work around community advisory board member's schedules by the program's facility administrator mailing a letter, thirty days in advance of the scheduled meeting to increase attendance for all three scheduled meetings. Reviewed community advisory board agendas and meeting minutes documented the program provides the board members with information regarding program updates, community updates, and giving back to the community. The next advisory board meeting is scheduled for September 28, 2019. An interview with the FA was conducted and confirmed community advisory board meetings are held quarterly. Board members provide suggestions to the program to improve community partnerships and provide innovative ideas for the youth. Community board members have been assisted in scheduling community service projects for the youth. Contact attempts with a board member during the annual compliance review to confirm participation was unsuccessful.

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

The program maintains a written policy and procedures for ensuring the program's planning, adequate staffing, and staff appreciation and recognition. The program conducts monthly staff meetings for each shift. Documentation of the monthly staff meeting agenda sign-in sheets for all-staff meetings for the past six months indicated staff meetings were conducted for each shift, as planned. A review of the monthly staff meeting agendas showed documentation addressing topics inclusive of training, performance guidelines, communication with staff and youth, staff dress code, safety and security, staff recognition, policies and procedures, and youth supervision. Each department has the opportunity to share with staff important updates. The program also has daily shift management meetings. Shift management meetings are conducted at the start of each shift to discuss youth behaviors, alerts, Protective Response Action Response (PAR) incidents, Florida Abuse Hotline calls and/or the Department's Central Communication Center (CCC) incidents, admissions, discharges, and any other important upcoming activities for the day. Additionally, the program conducts morning administration management meetings to discuss any issues or concerns in which administration may need to be aware of at the program. The program has a recognition program called the TrueCore Way which is designed to help motivate, retain, and increase staff morale. The program can provide gift cards to staff as incentives for performance and leadership. The program also has a staff of the month program and offers referral bonuses to staff. Staff come together for potlucks monthly which also helps increase morale. The program reviews the Comprehensive Accountability Report (CAR) with staff during staff meetings and utilizes the CAR for strategic planning. The program conducts surveys with staff and youth at least quarterly. The results of the surveys are incorporated into the program's planning process and recommendations to the program. The program also utilizes "Let's Talk" forms as an informal process to provide suggestions to the program. The program provides parent/guardian surveys to each parent/guardian who attend visitations quarterly. Five staff were interviewed, and three staff reported communication in the program is fair and two staff reported it is very good. Each staff stated staff meetings are held at least monthly and important information including staff assignments, training, changes in policies, youth supervision, documentation sight and sound, dress code, case management,

and staff recognition are discussed. Each interviewed staff reported the information discussed is valuable and informative. None of the interviewed staff reported being briefed on annual reports and/or youth or parent/guardian survey results. Each interviewed staff reported there is an open-door policy and communication can be shared during community meetings and staff meetings. An informal interview with the facility administrator (FA) was conducted. The FA stated the program has been working to reduce staff turnover since the last annual compliance review by working to increase morale through the TrueCore Way program, program potlucks, and staff recognition programs. The FA confirmed staff meetings are held monthly and suggestions, recommendations, training, policies and procedures, and long-term planning are just some of the topics which are discussed.

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

The program maintains a written policy and procedures ensuring the evaluation of staff performance. Performance evaluations are completed annually for all staff by department heads, as well as an initial ninety-day evaluation for newly hired staff. An informal interview with the facility administrator (FA) found each department head meets with staff annually to review performance and provide feedback on goals and performance. Each staff is also given the opportunity to provide comments and written input during this time. Performance evaluations address performance standards to include job duties, job knowledge and competency, teamwork, professionalism, goals achieved, and service at least annually. Evaluations are explicit to different categories of staff positions. Staff can be rated as exemplary, commendable, acceptable, or unacceptable. Each performance evaluation provides an overall numerical rating at the end of the evaluation. Five personnel records were reviewed in which two were supervisory records. Each included the specific job description and applicable performance evaluation. A review of the program’s contract indicated the contract requires a licensed mental health professional, nursing staff, and recreational therapist. The licensed mental health staff has been vacant since August 22, 2019 and nursing staff has been vacant since September 13, 2019. The program is currently using a staff member who does not meet the appropriate credential requirements for the recreational therapist position since July 16, 2019; however, are in the process of filling the position with qualified staff. Five randomly selected staff were interviewed. Four staff reported they receive an evaluation every six months and one reported annually.

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

The program maintains a written policy and procedures ensuring the active participation in a variety of structured recreation and leisure activities. Youth shall have the opportunity to make choices, assume meaningful roles, including team memberships, and leadership roles, and give input into the rules and operation of the residential community. A review of the program’s contract indicated the contract requires a recreational therapist with a bachelor’s degree in recreation and sports management with a track in recreational therapy. The program has not had a recreational therapist who met these qualifications in this position since July 16, 2019, when the qualified recreational therapist transferred to another position within the program. The program hired a new staff member which assumed the role of the recreational therapist on July 16, 2019; however, this staff member does not meet the current contract requirements for the

recreational therapist position. The staff member has a Masters of Arts in counseling and does not have any prior recreational therapy experience. Recreational therapy services are currently provided by a non-qualified staff. A review of the program's activity schedule found the program's recreational time is scheduled from 3:45 p.m. to 4:45 p.m. daily. Observations during the annual compliance review found the program does not consistently adhere to the scheduled time on the daily activity schedule. A review of the program's logbooks found the program does not consistently document recreation time in the logbook. The program has a pre-generated daily schedule which lists a variety of different activities scheduled throughout the month for youth to participate in ranging from football to core workouts. Documentation supported activities were planned to support social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. However, observations during the annual compliance review found the program is not consistently adhering to the planned activity on the daily schedule. An informal interview with the staff providing recreational services confirmed the staff was unfamiliar with the daily calendar schedule and reported not knowing there was a daily schedule. The staff reported the planned activities are typically football and basketball. The program takes precautionary measures to prevent over-exertion, heat stress, dehydration, frostbite, hypothermia, and exacerbation of existing illness or physical injury. The program completes individualized wellness plans which are separate from the therapeutic and performance plans. Individualized wellness plans focusing on weight, stress management, and impulse control are developed for each youth. A review of five youth records found each record contained a completed individual wellness plan. The program has a formal process in place which allows youth to provide constructive input and feedback to the program. The youth's advisory board meetings monthly to provide suggestions and recommendations on recreation and leisure activities. "Let's Talk" forms are also utilized to bring concerns or issues to staff. Surveys are given to youth quarterly as well. Five randomly selected staff were interviewed. Each interviewed staff reported youth receive daily outdoor and indoor recreational time. Each interviewed staff reported outdoor activities can include basketball, football, and/or general exercise and indoor activities are inclusive of cards, chess, or television time. Three staff reported indoor activities are generally one hour in duration, one staff reported indoor activities are all day long, and one staff reported they range from one to two hours long. Three staff reported outdoor activities are one hour in duration, one staff reported outdoor activities range from one to four hours in duration, and one staff reported outdoor activities are two hours long. Interviews completed with five randomly selected youth revealed the youth participate in football, basketball, stretching, group exercises, and tournaments. Each interviewed youth reported being provided with varying degrees of mental and physical exertion throughout the day.

Standard 2: Assessment and Performance Plan

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

The program maintains a written policy and procedures ensuring each youth's parent/guardian is notified by telephone within twenty-four hours of admission and maintain written correspondence within forty-eight hours of admission. Additionally, the program must notify the youth's committing court and assigned juvenile probation officer (JPO), in writing, within five working days of admission. A review of five youth case management records found each included documentation to support initial contact was made to the parent/guardian by telephone and in writing within the required time frames. Each of the five reviewed records included documentation the program notified the committing court, assigned JPO, and post-residential services counselor, when applicable.

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

The program maintains a written policy and procedures ensuring all youth complete an orientation to the program rules, expectations, goals of the program, and services applicable to youth within twenty-four hours of admission. The program provides each youth an orientation to the program rules, procedures, schedules and services. The orientation includes rules governing conduct and positive and negative consequences for behavior, availability of and access to medical and mental health services, access to the Florida Abuse Hotline, items considered contraband, dress code and hygiene practices, procedures on visitation, mail, use of the telephone, information on progress planning, anticipated length of stay in the program, and expectations for release from the program. Guidelines on grievance procedures, the program's zero-tolerance policy regarding sexual misconduct, special accommodations, and policies and procedures on reporting sexual misconduct, emergency procedures, and the physical design of the facility are also part the of the orientation. A review of five youth case management records found each contained documentation of a youth acknowledgement form confirming receipt of orientation. All documentation was in accordance to the policy timeframes. Expectations and responsibilities of youth, the daily schedule and the written behavioral management system is posted or provided in a resident handbook to allow easy access for youth. Five youth were interviewed and each reported receipt of orientation within twenty-four hours of admission. During the annual compliance review, there were no new admissions to the program.

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

The program has a written policy and procedures to address obtaining written consent of youth eighteen years of age or older prior to discussing or providing the parent/guardian any information related to the youth's physical or mental health screening or assessment. Five youth case management records were reviewed, and none were applicable. The program only had two youth over the age of eighteen years old since the last annual compliance review and both records were reviewed. Each applicable record contained a consent form signed by each youth prior to any 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 which may be used as potential weapons or means of escape, or participation in any off-campus activity.*	

The program maintains a written policy and procedures ensuring a classification system is in place in accordance with Florida Administrative Code. The program has a policy in place to ensure the assessment and reassessment of youth based on safety and security and the determination of each youth's individual needs and risk factors. The program conducts reassessments warranted upon changes in the youth's supervision status, new and/or updated alerts, relevant information available to the treatment team, and/or behavioral concerns. The program's classification form includes maturity level, age, history of violence, mental health and substance abuse history, medical records, security risk, and vulnerability to victimization. Five youth case management records were reviewed. Each reviewed record contained documentation to validate youth were classified based on physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation (if applicable), criminal behavior, and sexual aggression or vulnerability to victimization. In addition, each reviewed record had documentation to support each youth was classified based on suicide, medical, security, and escape risks prior to making any room or unit assignments. A review of the Vulnerability of Sexual Aggressive Behavior (VSAB) Assessment was completed prior to the classification of each youth and entered into the Department's Juvenile Justice Information System (JJIS) prior to each youth's room assignment. Classification forms documented all key staff were present during the classification meeting. The program maintains an internal alert board in the administration building for staff accessibility. A review of JJIS found no discrepancies or issues affecting classification within the program. An interview with the facility administrator (FA) was conducted. The FA confirmed the program utilizes a comprehensive classification system to address all risk factors prior to making any placement and room assignments. All classifications are discussed with all treatment team members. All classification reassessments are completed monthly and maintained in a risk assessment

binder. Five youth were reviewed for reassessments for classification. A review of the Risk Assessment binder documented each youth was assessed for the level of privileges or freedom of movement, use of tools, and participation in off campus activities.

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

The program maintains a written policy and procedures to address gang identification which includes the process to gather information on gangs and to notify local law enforcement of youth with suspected criminal gang activity. The program provides gang intervention and intervention services/activities to any youth identified as or suspected gang members. Five youth records were reviewed and only one was applicable for gang involvement. Two additional records were requested to meet the minimal sample size. Each of the three youth case management records contained documentation showing notification to law enforcement was made to the local law enforcement agency. Law enforcement is notified by electronic mail by the program's facility administrator (FA) and/or case manager. Additionally, in each reviewed record, documentation validated there was notification made to the school district providing educational services, the youth's juvenile probation officer, and post-residential provider. The program identifies youth who are suspected gang members at admission and enter the appropriate alert in the Department's Juvenile Justice Information System (JJIS). Youth who are identified as a suspected gang member after admission have an appropriate alert entered into JJIS, as well as documented on the program's internal alert system. Additionally, the assigned case manager will notify the appropriate law enforcement agency of the youth's gang status. Reviewed documentation validated all gang alerts were maintained in JJIS.

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

The program maintains a written policy and procedures ensuring youth who are identified as, or suspected gang members are provided gang prevention and intervention services and activities. The program maintains a binder which contains documentation on youth who have been identified as gang members or suspected to have associated with a gang. One of the five reviewed youth case management records was applicable for gang association; therefore, two additional records were requested to meet the minimum sample size. Each of the applicable records included performance plan goals addressing gang prevention and intervention strategies. Additionally, all identified youth were assigned to participate in the Impact of Crime (IOC) curriculum which the program utilizes as their gang intervention curriculum. Reviewed sign-in sheets for the past six months validated this practice.

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

The program maintains a written policy and procedures ensuring completion of the Residential Assessment for Youth (RAY) for each youth within thirty days of admission. A review of five case management records confirmed the RAY was completed within the established timeframe of thirty days of each youth's admission to the program. The initial RAY was maintained in the Department's Juvenile Justice Information System (JJIS) for each reviewed record. Each reviewed record was applicable for a Ray Reassessment. Each reassessment was completed within ninety days on the initial assessment. Appropriate updates were completed when applicable, and the reassessment documentation was maintained in the youth's 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 initial assessment process in JJIS on the YNAS.	

The program maintains a written policy and procedures ensuring a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission and documented in the Department's Juvenile Justice Information System (JJIS). Five youth case management records were reviewed. Documentation validated a YNAS was completed for each youth within thirty days of admission. All of the applicable documentation and the original YNAS was maintained in JJIS and a copy of the YNAS was maintained in each youth's case management record.

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

The program maintains a written policy and procedures ensuring the intervention and treatment, including the youth, meet and develop an Individual Performance Plan (IPP) within the initial

thirty days of admission into the program. Five youth case management records were reviewed and found three records contained an IPP created within thirty days of admission. Two youth case management records contained IPPs which were created past thirty days of admission. One IPP was six days late and one IPP was sixteen days late. Each of the five reviewed records contained documentation to support the IPP was developed after the initial assessment was completed. Each reviewed IPP included acknowledgment of participation and development by the youth, treatment team leader, medical staff, therapist, administrative representative, education staff, living unit representative, and parent/guardian. None of the reviewed records were applicable for participation by a Department of Children and Families (DCF) or Agency for Persons (APD) with Disabilities caseworker. Reviewed documentation confirmed each IPP was signed by the youth, intervention and treatment team leader, parties involved in goals, and parent/guardian. Additionally, each record contained documentation to support the parent/guardian returned the signed signature sheet to the program and a copy was maintained in the youth case management record. Each of the five reviewed IPPs was inclusive of individualized goals based upon prioritized needs, top three criminogenic needs addressed, delinquency interventions, measurable goals, and transition activities. One of the five reviewed IPPs was applicable for targeted court-ordered sanctions and the IPP clearly documented each sanction. Each reviewed IPP outlined staff and youth responsibilities with targeted completion dates. Each reviewed IPP also contained documentation to validate a copy of the IPP was sent to the committing court, juvenile probation officer (JPO), and parent/guardian. None were applicable to be sent to a DCF caseworker. Five randomly selected youth were interviewed. Each youth confirmed participating in the development of the IPP and receiving a copy. Each youth reported being aware of the goals on the IPP.

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

The program maintains a written policy and procedures addressing performance plan revisions. Revisions to the performance plan may be completed based upon Residential Assessment for Youth (RAY) Reassessment results, newly acquired charges/warrants, youth's progress towards goals or lack of progress. Five youth case management records were reviewed and three were applicable for revisions to the original Individual Performance Plan (IPP). The other two records were not applicable for revisions. Documentation confirmed revisions were made to each IPP based on the RAY Reassessment results, newly acquired information, progress and/or lack of progress of completing a goal. Two active youth case management records and one closed youth case management record was reviewed, and documentation supported each IPP was revised to facilitate transition activities during the last sixty days of each youth's stay in the program.

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.*	

The program maintains a written policy and procedures regarding performance plan transmittals. Performance summaries must be completed at least every ninety days and prior to youth's discharge or release from the program. Five active youth case management records were reviewed, and each was applicable for completion of performance summary updates every ninety days. Each applicable record contained documentation to confirm performance summaries were updated every ninety days. Each summary included reports and progress on performance goals, education, behavior, treatment progress, mental health, staff and peer interaction, youth's level of motivation to change, significant events, and anti and pro-social behaviors. Reviewed documentation supported each summary had a justification for release, discharge, or transfer. Each of the reviewed applicable records contained documentation to validate all required signatures inclusive of the treatment team leader, staff member preparing summary, facility administrator or designee, and youth all signed the performance summary. Each performance summary in the three applicable records found the youth are able to provide comments and youth are provided a copy of the summary. A review of each record found the original summary is filed in the youth case management record. Documentation validated a copy of each summary was sent to the committing court, youth's juvenile probation officer (JPO), youth, and parent/guardian. None of the reviewed records had Department of Children and Families (DCF) involvement.

Three additional closed youth case management records were reviewed for release summaries. Each reviewed closed record found documentation which reflected the Pre-Release Notifications and original release summaries were sent to the committing courts and assigned JPO at least forty-five days prior to each youth's scheduled discharge date. Each reviewed closed record found documentation to validate the program provided written notification to the youth's parent/guardian of the youth's planned release and completed a Residential Assessment for Youth (RAY). Each reviewed record found transition plans and performance summary were provided to the JPO upon completion. No psychological/psychiatric reports were conducted on any of the youth while in the program during the annual review period. JPO notification was made in the required timeframe. None of the reviewed records were applicable for the sexually violent predator program (SVPP) or victim notification. Five randomly selected youth were interviewed, and each youth reported they received a copy of their performance plan and were given the opportunity to read and write comments.

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 maintains a written policy and procedures to ensure parent/guardian involvement in the case management process including assessment, performance plan development, treatment team meetings, progress reviews and transition planning. Five youth case management records were reviewed, and each record had documentation of parental/guardian involvement in the creation of the Individual Performance Plan (IPP). The program's practice is to allow parents/guardians to participate by telephone or Skype if they are unable to attend any meetings. Parents/guardians are notified in advance and invited to participate for all schedule meetings for the youth. The program also schedules quarterly family days. An interview with the facility administrator (FA) confirmed this practice. Additionally, the FA reported youth are permitted to call the parent/guardian upon admission and on a weekly basis. During the annual compliance review, a treatment team meeting was observed. Observations of two formal youth treatment team meetings found the treatment team leader, youth, administrative representative, living unit representative, treatment staff, parent, gang prevention specialist and transition services manager were in attendance. Education staff was not present; however, provided written input in advance of the meeting. Attempts were made to reach the juvenile probation officers (JPO) for each youth during the treatment team meeting; however, a response was not received. None of the youth had any involvement with Department of Children and Families (DCF) or Agency of Persons with Disabilities (APD). All members in attendance were observed actively participating in the meeting either in person or by telephone. Each youth explained the progress they made in the program and on their specific performance goals since the last treatment team meeting. Each youth reported having parent/guardian involvement in case management activities.

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 program maintains a written policy and procedures ensuring there is program representation to participate in intervention and treatment services. The program assigns representatives from each department area to participate in the formal treatment team review. Formal treatment team reviews for each youth are conducted at least once every thirty days. Informal treatment team reviews are conducted at least once within thirty days. A review of five active youth case management records found documentation in each record to support the youth's juvenile probation officer (JPO), parent/guardian and other pertinent parties were invited and encouraged through advanced notification to participate in the youth's treatment team meeting. Each youth case management record documented meeting attendees to include the youth, representatives from program administration and living unit and others directly responsible for providing or overseeing intervention and treatment services. Observations of two formal youth treatment team meetings during the week of the annual compliance review found the treatment team leader, youth, administrative representative, living unit representative, treatment staff, parent/guardian, gang prevention specialist, and transition services manager were in attendance. Education staff was not present; however, provided written input in advance of the meeting. Attempts were made to reach the juvenile probation officer (JPO) for each youth during the treatment team meeting; however, a response was not received. None of the youth

had any involvement with Department of Children and Families (DCF) or Agency of Persons with Disabilities (APD). All members in attendance were observed actively participating in the meeting either in person or by telephone. Each youth explained the progress they made in the program and on their specific performance goals since the last treatment team meeting.

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.	

The program maintains a written policy and procedures for the intervention and treatment to reference or incorporate each youth's treatment or care plans into the youth's performance plan. A review of five youth case management records found each record had plans which included specific interventions to address academic performance, wellness, safety plans, mental health, and substance abuse goals identified from other plans and areas of the program. Each reviewed record contained documentation to support the inclusion of goals from the Individual Treatment Plan, Individual Academic Plans, and program sanctions. The program had no applicable youth for involvement in Department and Children and Families (DCF) and Agency for Persons with Disabilities (APD).

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

The program maintains a written policy and procedures ensuring formal and informal team meetings are conducted. Formal and informal treatment team meetings are each conducted once every thirty days. A review of five youth case management records found each youth record was applicable for both formal and informal treatment team meeting reviews. Each of the applicable records documented formal performance reviews to include the youth's name, date of review, comments from the treatment team, positive and negative behaviors, and a synopsis of the youth's progress on performance plan goals. Documentation for each performance review included the opportunity for the youth to demonstrate the new skills acquired in the program. None of the formal performance reviews were applicable for performance plan revisions or youth behaviors resulting in physical interventions. Each reviewed record had a Residential Assessment for Youth (RAY) Reassessment completed and results were documented.

A review of five active youth records found each record was applicable for informal performance reviews. Each of the applicable records documented informal performance reviews to include the youth's name, date of review, and meeting attendees. Each informal performance review documented comments from treatment team members, a synopsis of the youth's progress on performance plan goals, positive and negative behaviors, the youth's opportunity to demonstrate skills learned, and treatment progress. None of the informal performance reviews reviewed were applicable for performance plan revisions or youth behaviors resulting in physical interventions.

Observations of two formal youth treatment team meetings during the week of the annual compliance review found the treatment team leader, youth, administrative representative, living unit representative, treatment staff, parent/guardian, gang prevention specialist and transition

services manager were in attendance. Education staff was not present; however, provided written input in advance of the meeting. Attempts were made to reach the juvenile probation officer (JPO) for each youth during the treatment team meeting; however, a response was not received. None of the youth had any involvement with Department of Children and Families (DCF) or Agency of Persons with Disabilities (APD). All members in attendance were observed actively participating in the meeting either in person or by telephone. Each youth's treatment progress was discussed, and any positive and negative behaviors as well. Each youth explained the progress they made in the program and on their specific performance goals since the last treatment team meeting. Each youth was given the opportunity to demonstrate skills they have acquired during the time in the program. None of the youth had any behaviors resulting in physical interventions which needed to be addressed. Five randomly selected youth were interviewed. Four out of five youth reported being involved in treatment team meetings and being able to demonstrate skills acquired during the time in the program. One youth reported not participating in a treatment team meeting yet.

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

The program maintains a written policy and procedures ensuring staff develop and implement a vocational competency development program. The program offers a Type 2 educational programming through the Lee County School District which offers personal accountability skills and behaviors, interpersonal and decision-making skills appropriate for youth in all age groups and ability levels, and are geared to help youth maintain employment. The vocational programming provides an orientation to each youth with career choices based on personal abilities, aptitudes, and personal interests. The lead educator was interviewed. The lead educator confirmed career education is part of the daily planning for academics and built into core academic classes are opportunities for youth to develop abilities in communication, interpersonal skills and decision-making skills. Career assessments provide opportunities to explore and gain knowledge of occupation options. Youth in the program have opportunities to gain vocational certification in the food industry through ServSafe. The facility administrator (FA) was interviewed. The FA reported the program ensures youth are able to complete and/or obtain employment applications, resume, information on Career Source Center, social security card, birth certificate, state identification card prior to discharging from the program. Three closed youth records were reviewed for youth employability skills and each Individual Performance Plan (IPP) included an employment goal. Each reviewed record contained evidence of a completed sample employment application and resume. Each reviewed record contained documentation of an appointment with Career Source Center, appropriate documents to obtain employment, and documentation of notification to the parent/guardian and juvenile probation officer (JPO) being made aware of vocation plan. The program does not have a contracted minimum length of stay of nine months; therefore, the Career and Professional Education (CAPE) courses are not applicable to this program.

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 operates on a year-round academic calendar contracted with the Lee County School District. An interview with the lead educator confirmed youth are required to participate

in educational and career related programs for 250 days of instruction distributed over a twelve-month period, with a minimum of twenty-five hours of instruction weekly. Youth receive credits for educational and training experience. A review of five youth case management records confirmed youth have access to educational services. A review of the program's daily schedule and logbooks confirmed youth attended educational classes, as required and scheduled. Five randomly selected youth were interviewed, and four out of five youth confirmed minimal interference of education instruction during the school day. One youth reported sometimes youth interrupt the teachers.

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

The program maintains written policy and procedures in place regarding educational transition planning. Staff and youth at the program complete an education transition plan prior to release including provisions for continuation of education and/or employment. Three closed youth records were reviewed, and each contained documentation of an individual education transition plan developed prior to the youth's discharge from the program which was based on the youth's post-release goals, beginning at admission. Documentation supported each key personnel, including the youth, parent/guardian, educational staff with access to the district's management information system, certified school counselor, Department personnel, and post-release/re-entry staff provided input regarding each youth's education transition plan. Each plan addressed the different services and interventions based on the youth's educational needs and post-release educational plans. Documentation validated each plan identified the specific individuals responsible for monitoring the reintegration and coordination of the provisions and support services. Each plan was based on individual needs and performance. Each reviewed record was for youth with employability as a transition goal and each plan included provisions for continuation of education or employment, a completed employment application, a resume, valid Florida identification card, and information to the local Career Source Center. Each record reflected the youth's case manager and parent/guardian was aware of the documents and post-release discharge plan

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

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

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

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

The program maintains a written policy and procedures ensuring the intervention and treatment team is planning for the youth's successful transition to the community upon release from the program. A review of three closed youth records found each was applicable for transition planning, conference and Community Re-Entry Team meeting (CRT). A review of documentation found each transition conference was held at least sixty days prior to the targeted release date and included intervention and treatment team members. Signatures of the youth, treatment team leader, facility administrator or designee, and other treatment team members were observed in each of the reviewed youth records. Advanced notification of the scheduled meeting was sent to the juvenile probation officer (JPO), parent/guardian, education staff, and other relevant parties and was documented in each reviewed youth record. Transition activities were reviewed during the transition conference for each youth, including identification of individuals responsible for completion of the transition activities and target dates for completion. Each reviewed plan had documentation of signatures of all required parties representing their acknowledgement of the goals, responsibility, and accountability for completion. None of the reviewed records were applicable for performance plan revisions. A copy of the transition plans were sent to individuals responsible for the completion of transition goals who were unable to attend the meeting. A review of correspondence within the youth records supported a request for review, signature, and return of the plan was made when the plan was sent. One of three reviewed youth records documented an email acknowledgement receipt was received from the juvenile probation officer (JPO) when they received a copy of the transition plan. Two youth records did not document an acknowledgement receipt for the electronically submitted transition plan. A review of three closed youth records found each documented a CRT meeting was held in advance of the youth's release from the program and included participation by the youth and case manager. One of the three youth records reviewed did not contain a copy of an invitation for all requisite individuals to participate in the meeting.

2.20 Exit Portfolio	Satisfactory Compliance

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

The program maintains a written policy and procedures to ensure the development of a comprehensive exit portfolio for each youth. A review of three closed youth case management records validated the program completed exit portfolios for each youth to help assist in the

successful transition and reintegration back into the community. Each record contained documentation to show the exit portfolio was discussed and initiated for the youth at the transition conference. Each record contained a copy of the youth's state-issued identification card, copy of the transition plan, calendar with dates, times, and locations of upcoming appointments for the youth in the community, social security card, birth certificate, vocational/educational certificates, educational records, and school transcripts. Each record contained a resume, completed sample job applications, and documentation the education staff forwarded the educational information to the receiving school district. Reviewed documentation confirmed each exit portfolio was verified at the exit conference, the youth signed for a copy of their exit portfolio upon their release and the parent/guardian, and juvenile probation officer were forwarded copies of the exit portfolio.

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

The program maintains a written policy and procedures for conducting the exit conference. The exit conference should be a meeting to discuss the status of goals developed at the transition conference and finalize any release plans. Three closed youth case management records were reviewed and confirmed the exit conference was conducted after the program notified the juvenile probation officer (JPO) of the youth's release. Each exit conference was held at least fourteen days prior to the youth's release. Reviewed documentation validated each exit conference was documented in the case record, including the date, signatures (names if by telephone), and a summary of pending transition goals. Reviewed documentation confirmed each exit conference reviewed the transition activities established at the transition conference and finalized the plans for the youth's release. A review of the Department's Juvenile Justice System (JJIS) found each date of admission and release correlated with the dates entered in JJIS. Reviewed documentation confirmed the youth, the youth's JPO, the youth's parent/guardian, education representative, and any other pertinent parties participated in the exit conference. Each exit conference was separate from the transition and community re-entry team meetings.

Standard 3: Mental Health and Substance Abuse Services

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

The program maintains a written plan and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program's mental health and substance abuse facility operating procedures documented review and signature by the psychiatrist and designated mental health clinician authority (DMHCA) on September 25, 2018, the facility administrator on July 30, 2019, and the corporate officer on July 10, 2017. The program's DMHCA is responsible for the oversight of mental health and substance abuse services within the program. A review of the DHMCA's job description verified the responsibility of facilitating mental health and substance abuse treatment authority at the program to include clinical supervision, ensuring compliance with treatment requirements, ensuring completion of documentation in accordance with all state and federal guidelines, oversight of psychological and treatment services, participation in administrative programming, and providing on-call emergency consultation services.
The program's DMHCA is a licensed mental health counselor (LMHC). A review of the license showed it was clear and active in the State of Florida with an expiration date of March 31, 2021. The program's DMHCA reported providing daily oversight of clinical services while ensuring integrity and fidelity of treatment is maintained. Additionally, the DMHCA confirmed the responsibility of overseeing the mental health and substance abuse evaluation and treatment process and conducting at least one hour a week of on-site clinical supervision. The program's DMHCA is scheduled to be on-site Monday through Friday from 9:00 a.m. to 5:00 p.m. and provides on-call crisis and consultation services seven days a week, twenty-four hours a day. Interviews with the program's facility administrator and DMHCA reported the program offers specialized substance abuse treatment overlay services to all youth.

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 clinical treatment staff includes a licensed designated mental health clinician authority (DMHCA), one full time licensed therapist, and three master's-level therapists. The program's licensed therapist position has been vacant since August 22, 2019; however, the program has completed and scheduled interviews for potential candidates. An interview with the program's DMHCA reported the corporate office is currently in the process of making an offer to a licensed therapist interviewed on September 14, 2019. The program's previous licensed

therapist held a free and clear licensed mental health counselor (LMHC) license in the State of Florida. The program's mental health team also consists of a licensed psychologist who offers services up to four hours a week, as needed. The program's psychologist position became vacant March 31, 2019. An interview with the program's DMHCA revealed the corporate office was currently working to finalize an independent contractor agreement with a new psychologist. A review of the previous psychologist's license showed it was free and clear in the State of Florida with an expiration date of May 31, 2020. Additionally, the program maintains an agreement for professional services with a State of Florida American Board of Psychiatry and Neurology certified licensed psychiatrist who is scheduled to be on-site weekly. A review of the psychiatric license reflected the license was clear and active in the State of Florida with an expiration date of March 31, 2020. Reviewed documentation found each licensed clinician maintained a clear and active license in the State of Florida. Reviewed training records reflected each staff was working within the scope of their licensure, experience, and training. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was active and expires April 7, 2020. An interview with the program's DMHCA verified both the DMHCA and psychiatrist are on-call for emergencies and consultation twenty-four hours a day, seven days a week.

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 a designated mental health clinician authority (DMHCA), and three non-licensed, master's-level therapists currently providing services to youth at the program. A review of clinical supervision documentation for the past six months showed each of the program's non-licensed master's-level therapists received weekly face-to-face supervision by the licensed DMHCA each week services were provided. Each reviewed direct supervision log was documented on the program's form and included all elements outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log. The reviewed clinical supervision logs included detailed information inclusive of case history, caseload directions, review of fidelity checks, clinical service instructions, documented strengths, findings, trends, and/or problem areas, situational concerns, and training. A review of the training records for the three non-licensed staff validated completion of the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Training documentation also included the administration of five Assessments of Suicide Risk or Crisis Assessments conducted on-site in the physical presence of a licensed mental health professional and was documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. A review of each therapist's caseload assignment showed each was within the contractual limit of sixteen youth. The program maintains an agreement for professional services with a State of Florida American Board of Psychiatry and Neurology certified licensed psychiatrist who is scheduled to be on-site weekly. The program has an agreement with a certified behavior analyst (CBA), and a certified addiction professional (CAP) who offer services up to four hours a week, as needed. The program's psychologist position became vacant on March 31, 2019; however, the previous licensed psychologist was providing on-site services for up to four hours a week, as needed. An

interview with the program's DMHCA reported the corporate office was currently working to finalize an independent contractor agreement with a new psychologist. A review of staff records demonstrated each staff worked within the scope of their licensure and/or certification, experience, and training. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was active and expires April 7, 2020. The interviewed DMHCA also reported communication between clinical staff at the program includes informal daily communication, formal weekly clinical supervision, and coaching sessions on an as needed basis.

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

The program maintains a written plan and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The policy outlines the pre-screen process by which a youth's individualized history is reviewed and an admission screening is completed. A review of five individualized mental health and substance abuse records showed the program administered a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) screening on the day of admission. Each reviewed record documented a review of available information to include the commitment packet, reports, and records of existing documentation of mental health or substance abuse problems on the program's document review form. A review of training records confirmed each of the five records contained screenings administered by a trained mental health staff member working under the direct supervision of the licensed DMHCA. Each of the five reviewed MAYSI-2 screenings was initially completed using a paper questionnaire and scored using the Department's Juvenile Justice Information System (JJIS). Four of the five records documented the screening was scored the same day and one documented the screening was entered and scored in JJIS four days later. Three of the five reviewed records indicated the need for further assessment based on screening results and the need for further assessment was clearly checked on each form. The program's practice is to refer all newly admitted youth for a comprehensive evaluation and an Assessment of Suicide Risk (ASR) regardless of MAYSI-2 screening results; therefore, the program does not utilize a separate mental health referral form. None of the five reviewed records were applicable for requiring immediate attention due to an identified crisis or emergency based on the MAYSI-2 screening results. An interview with the facility administrator confirmed the program's use of the MAYSI-2 as part of the screening process utilized to identify youth at risk for mental health, substance abuse, and/or suicide upon 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.	

The program maintains a written plan and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The policy outlines the process by which all youth are referred to a mental

health service provider for the completion of a comprehensive mental health and substance abuse evaluation. The program policy is to complete a new comprehensive mental health and substance abuse evaluation regardless of identified needs for each new admission. A review of five individualized mental health and substance abuse records showed each youth record contained a new evaluation completed within thirty days of admission. Each of the five reviewed comprehensive evaluations were completed by a master's-level clinician working under the direct supervision of the licensed designated mental health clinician authority (DMHCA). All five evaluations were reviewed and signed by the licensed staff within ten calendar days, as required. Each new comprehensive evaluation contained identifying information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, procedures administered, discussion of findings, diagnostic impressions, and recommendations. All five reviewed records were applicable for a substance abuse diagnosis and contained a substance abuse assessment. Each record documented a consent for substance abuse services and urinalysis dated the day of admission. Each substance abuse evaluation was completed within thirty days and documented the reason for assessment, behavioral observations, methods of assessment, patterns of alcohol and drug abuse, impact of alcohol and drug abuse on major life areas, risk factors of continued alcohol and drug abuse, clinical impressions, recommendations, and the original referral reason. An interview with the program's DMHCA reported assessments completed upon admission and throughout treatment include the Reynolds Adolescent Depression Scale - Second Edition, Adolescent Psychopathology Scale™ Short Form, Trauma Symptom Checklist for Young Children™, Trauma Symptom Inventory™, Substance Abuse Subtle Screening Inventory, and Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). The DMHCA further explained the initial assessment, as well as the follow-up assessment results, are included within the comprehensive mental health and substance abuse evaluation. It was additionally reported comprehensive evaluations also include parent/guardian interview information, the youth's juvenile probation officer interview information, and a summary of the youth's initial behaviors exhibited at the program.

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

The program maintains a written plan and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program's mental health and substance abuse plan states mental health and substance abuse treatment services are available to all youth at the program who are determined to meet clinical criteria. Additionally, mental health and substance abuse treatment is provided on-site through the provision of substance abuse treatment overlay services (SAOS). The program's SAOS services include record review, bio-psychosocial evaluation, substance abuse assessment, drug screening, mental health evaluations for youth with a co-occurring mental disorder, individualized substance abuse treatment planning, psychiatric services, medication management, individual, group, and family substance abuse counseling, crisis management, twenty-four-hour suicide prevention services, and emergency management services. The program's plan for mental health and substance abuse services

indicated all youth are prescribed treatment based on their identified individualized needs, and at a minimum, all youth shall receive bi-weekly individual therapy sessions, monthly family sessions, and daily clinical group services. The delivery of SAOS services at the program also include supportive counseling, and substance abuse treatment and education groups to include prevention, intervention, relapse prevention, and the twelve-step model. Each newly admitted youth is assigned to a multidisciplinary intervention and treatment team within the admission intake and classification process. The program's treatment team assists the primary therapist in development, review, and updating of initial and individualized treatment plans.

A review of five individualized mental health and substance abuse records documented each youth was assigned to a treatment team on the day of admission. Each of the five reviewed records contained an active Authority for Evaluation and Treatment (AET) form, a substance abuse treatment consent form, and a urinalysis consent form. The program is licensed under Florida Statute, Chapter 397, and certified through the Florida Department of Children and Families (DCF) to provide substance abuse services for adolescents. Each of the five reviewed mental health and substance abuse treatment records contained notes which included all elements of the Department's Counseling/Therapy Progress Note form. Weekly progress notes are maintained by an assigned counselor for each youth. Each reviewed weekly progress note form contained youth identifying information, date of services, start and end time of services, type of service, number of participants, curriculum, clinical interventions, youth response, summary of overall progress in treatment for the week, goals addressed during the week, summary of significant events, summary of family involvement, and the primary counselor's signature. A review of five individualized mental health and substance abuse records showed youth received mental health and substance abuse treatment, as prescribed, with two exceptions. One youth record did not document a family session was attempted or conducted for April 2019; however, two sessions were conducted in May 2019. A second record reflected the youth only received one of the two prescribed individual sessions for July 2019.

An interview with the program's designated mental health clinician authority (DMHCA) reflected mental health and substance abuse services are tracked through each youth's weekly progress note and through a service tracker for individual and family therapy sessions. The program's contract outlines four mental health groups and four substance abuse groups to be provided to youth at the program. All clinical groups are facilitated by the program's trained master's-level mental health staff. Mental health group offerings include Controlling Ourselves, Don't Let Emotions Run Your Life, Teen Relationships, and Life Skills as required. A review of the program schedule, youth case notes, and an interview with the DMHCA revealed the program was only providing two of the four contractually outlined substance abuse groups. The contract outlines Anger Management for Substance Abuse and Mental Health Clients, Living in Balance, Seeking Safety, and Pathways to Self-Discovery and Change to be provided; however, the program was not providing Seeking Safety or Pathways to Self-Discovery and Change during the annual review period. The program updated the schedule and initiated a new Pathways to Self-Discovery and Change group during the annual compliance review week. An interview with the DMHCA reported none of the current master's-level therapists were trained to facilitate the Seeking Safety trauma informed substance abuse curriculum at the program. Five youth were interviewed regarding participation in groups at the program. Each youth reported participating in group counseling at the program. Five staff were interviewed regarding which staff facilitate mental health and substance abuse groups at the program. Each of the five staff reported direct care staff do not facilitate groups and therapists facilitate groups. Observations of mental health and substance abuse groups during the annual compliance review week and reviewed sign-in sheets reflected mental health groups had no more than ten youth and substance abuse groups had no more than fifteen youth as required.

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

The program maintains a written plan and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program's mental health and substance abuse plan states treatment planning at the program includes an initial mental health and substance abuse treatment plan, an individualized mental health and substance abuse treatment plan, monthly treatment plan reviews, and discharge planning. A review of five individualized mental health and substance abuse records showed an Initial Treatment Plan was developed on the day of admission. Each Initial Treatment Plan was documented on the program's form and contained all elements outlined in the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Four reviewed Initial Treatment Plans were completed by a licensed mental health professional and one was completed by a master's level therapist working under the direct supervision of the licensed designated mental health clinician authority (DMHCA). The licensed staff signed the one plan completed by non-licensed staff within ten calendar days, as required. Each reviewed Initial Treatment Plan was also signed by all team members participating in the development of the plan. Each of the five reviewed Initial Treatment Plans also documented the youth's psychiatric needs to include prescribed medication and medication monitoring frequency, when applicable.

A review of five records showed each contained an Individualized Treatment Plan documented on the program's form containing all elements in the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. Each Individualized Treatment Plan form included youth identification information, youth Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, youth and family strengths, needs, ability preferences, services to be provided, clinical goals, youth interpretations of clinical goals, objectives, status, target completion dates, progress summary, summary of additional services, youth overall progress in the program, medication details, and treatment team member signatures. Each reviewed plan was developed within thirty days of admission and signed by the mental health staff creating the plan, the case manager, and the facility administrator. Three reviewed Individualized Treatment Plans documented signature of the living unit representative and two did not. Three of the reviewed Individualized Treatment Plans were completed by a non-licensed mental health staff and documented review and signature of the licensed DMHCA within ten days as required. Three records were applicable for psychotropic medication monitoring and clearly documented monitoring frequency, medication prescribed, and dosage information. An interview with the program's DMHCA reported each youth's individual record is reviewed, the youth and parent/guardian are interviewed, and a comprehensive assessment is completed prior to the creation of each Individualized Treatment Plan.

Five records were reviewed for Individualized Treatment Plan Reviews. Each reviewed Individualized Treatment Plan Review was documented on the program's form containing all the information in the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form. Each plan clearly documented identifying youth information, DSM-5 diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, clinical goals, youth interpretations of clinical goals, objectives, status, target completion dates, progress summary, summary of additional services, youth overall progress in program, medication details, and services to be provided. Each record also contained a monthly American Society of Addiction Medicine (ASAM) summary and recommendation form. A total of thirteen Treatment Plan Reviews were applicable in the reviewed five youth records. Each of the thirteen reviews contained signatures of treatment team members participating in the review; however, one review did not clearly document participation by signature of the program's administrative staff. An interview with the DMHCA reported within thirty days of the development of each Individualized Treatment Plan, every youth receives a treatment plan review during which their goals and objectives are reviewed and updated.

Three closed individualized mental health and substance abuse records were reviewed for the completion of Mental Health/Substance Abuse Treatment Discharge Plans. Each record contained a discharge plan documented on the program's form and included all elements outlined on the Department's Mental Health/Substance Abuse Treatment Discharge Plan form. Each of the three reviewed discharge plans were completed by the individualized treatment team on the same day of each youth's exit staffing. Each youth's discharge summary documented services needed, and documented youth and parent/guardian participation. None of the records were applicable for notification of suicide risk upon discharge. The program practice is to obtain the parent/guardian signature on the discharge plan upon the youth's release from the program. The parent/guardian is then provided with a copy of the plan. The program also sends all Mental Health/Substance Abuse Treatment Discharge Plans to the youth's juvenile probation officer (JPO) by mail upon release.

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

The program maintains a written policy and procedures for outpatient substance abuse services to establish a method in which substance abuse treatment services shall be provided to youth. Mental health and substance abuse treatment is provided on-site through the provision of substance abuse treatment overlay services (SAOS). The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment. The program also carries an active outpatient and residential treatment accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF). The program also utilizes the services of a Florida Board certified addiction professional (CAP) for up to four hours a week and on an as needed basis. A review of the CAP certification reflected all standards and qualifications were established by the Florida Certification Board. The program's CAP has not provided services since May 2019; however, the program's DMHCA holds an active master's-level certified addiction professional (MCAP) certification. The DMHCA has been providing CAP services in the interim. A review of the CAP's job description confirmed the responsibility of providing substance abuse treatment interventions. The program entered into an agreement with Adapt

and Transform Behavior, LLC on May 13, 2019 for the service delivery of a certified behavior analyst (CBA) for up to four hours a week and on an as needed basis. Prior to May 13, 2019 services were provided through an independent agreement with an individual provider. A review of the CBA certifications showed each of the two individuals providing CBA services during the annual compliance review period were certified through the Behavior Analyst Certification Board. A review of the CBA job description confirmed the responsibility of completing functional behavior assessments and individualized behavior plans as needed.

The program's mental health team also consists of a licensed psychologist who offers services up to four hours a week, as needed. The program's psychologist position became vacant on March 31, 2019; however, a review of the previous psychologist's license showed it was free and clear in the State of Florida with an expiration date of May 31, 2020. An interview with the program's DMHCA reported the corporate office was currently working to finalize an independent contractor agreement with a new psychologist. An interview with the program's DMHCA reported the program's psychologist provides consultation services in cooperation with the CBA. Reviewed documentation supported consultation services for youth were provided through referrals for neurological testing and targeted behavior intervention plans.

The program hosts a parenting support group on-site following monthly visitations using the Parenting Wisely curriculum. Each parent/guardian is also provided with online access to the Parenting Wisely curriculum to allow families to strengthen relationships and decrease family conflicts. The program also provided documentation to support transportation assistance, and lodging assistance is offered to youth's families as part of relationship development. A review of five individualized mental health and substance abuse records showed each contained an initial urine drug screen, at least one random urine drug screen, and a detoxification assessment form completed by the program's medical staff. A review of five individualized mental health and substance abuse records weekly progress notes supported the groups are provided to youth, as scheduled. Reviewed documentation supported youth have access to weekly on-site faith-based recovery groups. The twelve-step recovery program entitled Celebrate Recovery is facilitated by Grace Church.

Five youth were interviewed regarding participation in groups at the program and each youth reported participating in group counseling at the program.

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

The program maintains a written plan and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program's mental health and substance abuse plan outlines the role of a contracted psychiatrist for the management and oversight of psychiatric care. The program's psychiatrist responsibilities include supervision of the treatment team and providing psychopharmacological therapy to youth receiving psychotropic medications. In addition to a psychiatric evaluation, medical and psychiatric follow-up visits are conducted on an individualized basis. The program maintains an independent contractor agreement with a State

of Florida, board-certified, licensed psychiatrist executed on July 21, 2018. The program does not utilize an advanced registered nurse practitioner (ARNP). A review of the psychiatrist's license showed it was clear and active in the State of Florida with an expiration date of March 31, 2020. The psychiatrist is a licensed osteopathic physician with a specialty in child and adolescent psychiatry. A review of psychiatrist sign-in sheets since the last annual compliance review supported the psychiatrist is on-site weekly and participates in weekly treatment team meetings with the program's mental health staff. A review of five individualized mental health and substance abuse records showed each contained a new psychiatric initial diagnostic interview completed within fourteen days of admission. Each diagnostic interview documented youth history, Mental Status Examination, Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, applicable prescribed medications, frequency of medication monitoring, and treatment recommendations. All reviewed records documented the initial diagnostic psychiatric interview on the department's Clinical Psychotropic Progress Note (CPPN) form, and each contained page number three of the CPPN. Three youth records were applicable for the prescription of psychotropic medications prior to admission. Each youth was continued on prescribed medications and the explanation of the need for psychotropic medication related to the youth's diagnosis, target symptoms, initial treatment goals, potential side effects, and risks and benefits of taking the medication was clearly documented. The three reviewed records applicable for the prescription of psychotropic medications required a total of eight monthly medication management reviews. Each medication management review was completed within thirty days as required. Two of the three records applicable for prescribed psychotropic medications were applicable for a change to the youth's existing medications and page three of the CPPN was completed as required. An interview with the program's psychiatrist during the annual compliance review confirmed the psychiatrist's weekly site visit schedule and twenty-four hour on-call emergency consultation status. The program's DMHCA reported meeting with the psychiatrist weekly on-site to discuss all new admissions, medication management follow-ups, and all psychiatric referrals.

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

The program maintains a written policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The policy and procedures were signed by the facility administrator on July 30, 2019, and the corporate officer on July 10, 2017. The program also maintains an attached suicide prevention plan. The reviewed plan documented signature of the psychiatrist on February 7, 2019 and the program's designated mental health clinician authority (DMHCA) on July 11, 2018. The program's suicide prevention plan included provisions for admission screening, staff observation, assessment, documentation facility administrator notification, levels of supervision, suicide attempt or serious self-inflicted injury review and mortality review, and training. An interview with the program's facility administrator (FA) reported the program conducts emergency mental health drills, to include emergency response to suicide attempts or self-inflicted injury, at least quarterly on each shift.

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

The program maintains a written policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The program also maintains an attached suicide prevention plan. The prevention plan outlines provisions for screening, staff observation, assessment, documentation, levels of supervision, and staff training. The program's practice is to complete an Assessment of Suicide Risk (ASR) on the day of admission, regardless of intake screening results. Each of the five reviewed records documented and ASR was completed on the day of admission as part of the intake process. The program reported five youth requiring suicide prevention intervention services since the last annual compliance review and provided each for review. Four of the five applicable records documented an ASR was completed using the Department's ASR form within twenty-four hours, as required. One record documented a Crisis Assessment was completed where an ASR should have been completed. Each of the four records where an ASR was completed documented the reason for assessment as the youth self-reporting suicidal ideation. Each of the four records where an ASR was completed documented the youth was placed on precautionary observation and the parent/guardian and the juvenile probation officer (JPO) were notified. Each record also documented the completion of a Follow-Up ASR completed on the Department's form. Each reviewed ASR and Follow-Up ASR was completed on-site by a licensed mental health professional and a conference with the facility administrator was held prior to stepping a youth to close supervision. Each of the four records also documented the completion of a mental status exam prior to placing the youth on program standard supervision. A review of the program logbooks and the Department's Juvenile Justice Information System (JJIS) supported the program documented the beginning and end times of youth placed on suicide precautions. An interview with the program's designated mental health clinician authority (DMHCA) reported notifications are also made through an e-mail sent to the management team and the program's internal alert board. The program does not utilize secure observation. Five staff were interviewed regarding responsibilities of direct care staff if a youth expresses suicidal thoughts. All five staff reported they would notify the mental health staff, four also reported they would maintain constant sight and sound supervision of the youth, and two staff also reported they would document supervision. Each of the five interviewed staff reported a suicide response kit is located in the administrative area, four reported one is also located in the medical office, and one staff reported a kit is also located in the youth dormitory area. The program maintains three complete suicide response kits located in the administration area, medical office, and laundry room. The program also maintains an extra knife for life within all program first aid kits. The program's facility administrator (FA) reported the status of youth on precautionary observation is noted during each staff briefing and reviewed during the program's daily management meetings.

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

The program maintains a written policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The program also maintains an attached suicide prevention plan. The prevention plan outlines provisions for staff observation, documentation, and levels of supervision. The program reported five youth requiring suicide prevention intervention services since the last annual compliance review and provided each for review. Four of the five applicable records documented supervision on the Department's Suicide Precaution Observation Log form for the duration each youth was on suicide precautions. One record documented the youth was placed on constant supervision due to self-reported suicidal ideation. The youth's constant supervision status was documented on the Department's Mental Health Observation Log form versus the Suicide Precaution Observation Log form. The youth was on constant supervision status from July 30, 2019 through August 4, 2019; however, the Mental Health Observation Logs for August 1, 2019 was not provided by the program. All reviewed Suicide Precaution Observation Logs and Mental Health Observation Logs documented signature by mental health staff and the shift supervisor. The four reviewed Precautionary Observation Logs documented safe housing requirements and were documented in real time not exceeding thirty-minute intervals. There were no documented lapses in supervision on any of the reviewed logs. None of the reviewed Precautionary Observation Logs were applicable for documenting warning signs or the need for immediate consultation with mental health staff. Three youth previously placed on suicide precautions were interviewed during the annual compliance review. Each of the three youth reported never being left alone while on precautionary observation status.

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

The program maintains a written policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The program also maintains an attached suicide prevention plan. The prevention plan outlines provisions for screening, staff observation, assessment, documentation, levels of supervision, and staff training. The program also maintains a written training plan outlining the suicide training requirements for all program staff. All direct care and non-direct care staff receive ongoing on-site training regarding suicide prevention, crisis intervention, and emergency care. A review of five direct care staff training records supported each staff received six hours of annual suicide training, as required. The program's corporate office maintains a pre-determined regional drill schedule which includes mental health drills. The program has completed a total of twelve mock suicide drills in the last twelve months. Each completed drill included the use of life saving measures including the use of a first aid kit, a suicide response kit, cardiopulmonary resuscitation (CPR), and/or an automated external defibrillator (AED). A review of the program's mock suicide drills and mental health drills for the last twelve months supported drills are conducted quarterly. For the quarter for January through March 2019 two mental health drills were completed on second shift; however, no drills were conducted on first shift as scheduled. Each of the three remaining quarters documented drills were conducted quarterly on each shift. The program's roster

reflected twenty-six direct care staff applicable for participation in annual mock suicide drills. A review of the completed drills against the program staff roster showed nineteen of twenty-six staff members participated in mock drills at least semi-annually. Each reviewed drill documented a description of the incident, a synopsis of the response, identified deficiencies, corrective action, and staff members involved. An interview with the programs designated mental health clinician authority reported mock suicide response drills are led, documented and critiqued by the mental health staff. Drills are also reviewed during the program's morning management meetings and during mandatory monthly all staff meetings.

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

The program maintains a written policy and procedures to establish a method of crisis intervention services to be provided to all youth. The policy and procedures was signed by the facility administrator (FA) on July 20, 2019 and the corporate officer on July 10, 2017. The program also maintains an attached crisis intervention plan. The reviewed plan documented signature of the psychiatrist on February 7, 2019 and the program's designated mental health clinician authority (DMHCA) on July 11, 2018. A review of the program's crisis intervention plan showed it included a process for ensuring safety and security, notification and alert system, referral, communication, supervision, documentation, and review, as required.

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 maintains a written policy and procedures to establish a method of crisis intervention services to be provided to all youth. The program also maintains an attached crisis intervention plan. The plan states crisis interventions will be provided as needed in a one-to-one setting for youth who require immediate processing relating to the specific incident. The program's crisis intervention service interventions include anger control issues, depressive symptoms, maladaptive coping mechanisms, and impaired impulse control. In the event a youth exhibits out of control behaviors, the program's direct care staff place the youth on mental health alert and refer to a qualified mental health professional for a crisis assessment. Two of five reviewed individualized mental health and substance abuse records were applicable for the completion of crisis intervention services. One additional record was requested and provided for

a sample size of three. The program utilizes the Department's Crisis Assessment form. Each of the three reviewed Crisis Assessments were completed on-site and documented the reason for assessment, mental health status examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, treatment recommendations, parent/guardian notification, and recommendations for follow-up. Two crisis assessments were completed by the licensed designated mental health clinician authority (DMHCA) and one was completed by a master's-level therapist. The assessment completed by the non-licensed staff was signed by the licensed mental health professional within twenty-four hours, as required. Each of the three assessments resulted in an increased supervision level and the corresponding alert was placed into the Department's Juvenile Justice Information System (JJIS) as required. Each youth was placed on constant supervision and observation logs were maintained on the Department's Mental Health Alert Observation form. Each reviewed record showed the youth was re-assessed, and a mental health status exam was completed prior to lowering the supervision level. There were no Prison Rape Elimination Act (PREA) allegations requiring a crisis assessment since the last annual compliance review.

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

The program maintains a written policy and procedures to establish a method in which emergency, metal health and substance abuse services will be provided to all youth. The policy and procedures were signed by the facility administrator on July 20, 2019 and the corporate officer on July 10, 2017. The program also maintains an attached emergency care plan. The reviewed plan documented signature of the program's designated mental health clinician authority (DMHCA) on July 30, 2019. A review of the program's emergency care plan showed it included a process for emergency identification and immediate staff response, notification, communication, supervision, authorization of transport for emergency services, transportation for mental health and substance use emergencies, mortality review, and staff training. The program utilizes SalusCare Children's and Adult's Crisis Stabilization Unit in Fort Meyers for youth under and over eighteen for mental health/Baker Act emergencies requiring involuntary placement and/or assessment. The program utilizes the Juvenile Addictions Receiving Facility in Fort Myers for youth identified with detoxification symptoms admitted under the Marchman Act proceedings.

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

The program did not utilize a Baker Act or Marchman Act procedure during this annual compliance review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

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

The program maintains a written policy and procedures ensuring a health authority shall be responsible for the healthcare services provided. The program maintains an independent contractor agreement with a State of Florida physician to serve as the designated health authority (DHA) signed on February 10, 2016. The DHA holds an active, unrestricted license under Chapter 458, Florida State Statute, with a license expiration date of March 31, 2020 and is an osteopathic physician with specialty training in pediatrics. The program does not utilize an advance registered nurse practitioner/advance practice registered nurse or physician's assistant. The DHA is scheduled to be on-site for approximately two hours weekly. Reviewed physician logs for the past six months supported the DHA was on-site weekly as required. In the event the DHA cannot be on-site, duties have been delegated to a medical doctor to act on behalf of the DHA. The medical doctor holds an active, unrestricted license under Chapter 458, Florida State Statute which expires on January 21, 2021. The DHA is responsible for communication with program staff regarding youth medical needs, and is available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The scope of services includes medical screenings, assessments and evaluations, provide medication evaluation and on-going monitoring of medications and chronic medical medications. Supporting documentation reflected the DHA consults and works with the treatment team members in developing and modifying treatment plans and performance plans, as needed. An interview with the DHA confirmed their role includes performing Comprehensive Physical Assessments, sick call, periodic evaluations, and reviews healthcare policies and procedures and nursing protocols. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist. The current license expires on March 31, 2020 and the certificate of insurance expires December 1, 2019. The psychiatrist is on-site once a week and meets with the nursing staff, clinical director, and case managers to discuss the needs of the youth and evaluate medication management. The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist license expires February 28, 2020. The optometrist license expires February 28, 2021.

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

The program maintains facility operating procedures for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation validated the DHA signed all healthcare policies and procedures on June 17, 2019, the facility administrator documented a review on July 9, 2019, and the psychiatrist documented a review on June 18, 2019. The program maintains two full-time registered nurses (RN) with one RN vacancy since September 16, 2019. One RN is the program's health services administrator (HSA). The program maintains a training requirement whereby newly employed healthcare staff shall receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, to include Florida Administrative Code 63-M, provided by HSA. Reviewed training

curricula and plan reflected a new RN would receive the required pre-service and orientation training to include on-the-job training. The program hired two new nursing staff since the last annual compliance review and reviewed documentation supported both completed the require training. The program maintains a nursing protocol manual developed and approved by the DHA on July 1, 2019. Reviewed nursing staff training records validated training on the treatment protocols and healthcare policies and procedures in July 2019. Treatment protocols were reviewed by the DHA on July 1, 2019 and remained effective without change to include admission standing orders, non-licensed medical and emergency protocol guide, body mass index protocol, and approved first aid kit content and designee.

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

The program maintains a written policy and procedures ensuring parents/guardians are afforded the right to give or withhold consent about the healthcare provided to their children. The Authority for Evaluation and Treatment (AET) form is signed by the parent(s) who have legal custody or by the legal guardian and the AET serves as informed consent for non-invasive medical procedures which can be treated by healthcare staff or for minor ailments requiring over-the-counter (OTC) medications. The signed AET is valid until the parent/guardian revokes or modifies it, or the youth leaves the custody of the Department. The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form and to whom the information can be released and shared. A review of five youth healthcare records found each was applicable for a signed AET. Each reviewed youth healthcare record contained a copy of the signed AET and the word “Copy” was clearly stamped on each. There were no original AETs reviewed. There were no youth in the custody of the Department of Children and Families. Each reviewed AET and/or Release of Information form was filed in each youth’s healthcare record in the appropriate section. An interview with nursing staff indicated the registered nurses review all admissions in the Department’s Juvenile Justice Information System (JJIS) and validates the AET. If needed, the assigned juvenile probation officer would be contacted through the case manager to obtain a new AET.

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

The program maintains a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth’s medical and/or mental health condition and to obtain consent when new medications and treatments are prescribed. Procedures also ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. Five reviewed healthcare records supported three were applicable for parental notification. Reviewed documentation supported each parent/guardian was notified when significant changes to existing medication occurred and when changes in condition and/or medication for youth identified with a chronic condition. Each of the five reviewed youth records required parental notification for over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET) and documentation supported parental notification was sent. One reviewed youth healthcare record was applicable for off-site emergency care and reviewed documentation supported the

parent/guardian were notified. The program had no other youth applicable for emergency care since the last annual compliance review. Verbal parental/guardian consent is obtained as soon as possible after an order is written. Verbal consent is obtained for any over-the-counter medication which has not been previously approved. For new prescriptions, significant dosage change, or for discontinuing a medication, a parental notification is also completed. All attempts are made to verbally contact the parent/guardian prior to a youth leaving for the emergency room (ER). The parent/guardian is also contacted upon the youth's return with the results of the ER visit. Written notification is completed after the return from the ER. Nursing interviews indicated parental/guardian notifications are written and sent the same day as the event to include off-site appointments, new intake, seen on-site by the designated health authority, and/or any other pertinent medical event. One of the five reviewed youth healthcare records supported the youth was prescribed a psychotropic medication; therefore, two additional applicable healthcare records were requested and reviewed. Documentation supported the required parent/guardian consents were obtained for each youth. The reviewed healthcare records documented a telephone consent conducted by the psychiatrist and witnessed by the nurse. The parents/guardians received a written follow-up of a copy of the Department's Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note. Copies of all correspondence were maintained in the applicable youth healthcare records. There were no applicable youth requiring immunizations; however, policy and procedures outline the AET provides an opportunity for parental consent to be obtained for missing vaccinations. At the time of signing the AET, the parent/guardian shall be provided with the relevant Vaccine Information Statements (VIS) to inform them of the potential risks and side effects. When the parent/guardian does not consent to the vaccinations, the Parent Notification of Health-Related Care: Vaccination/Immunizations form is sent with the required VIS to obtain consent. There were no applicable reviewed healthcare records of the parent/guardian not consenting due to religious reasons. Program practice is for the nursing staff to pull each youth's immunization record from the Florida Shots website within the first week of admission and have the designated health authority document a review of the record. This practice was confirmed by the nursing staff in an interview.

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

The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission and ensure a healthcare admission rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted. A review of five youth healthcare records supported each youth received an initial admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse (RN). An interview with the RN indicated a nursing assessment is conducted immediately following the initial search, normally within ten to fifteen minutes of the youth's arrival. The RN notifies the designated health authority (DHA) by telephone, by text, or verbally, if on-site, with the youth's history and identified chronic condition and documents the notification on the DHA Notification form and in the nursing admission chronological notes. The DHA Notification form is filed in the youth's healthcare record in the practitioner's chronological note section. Referrals are documented in the physician's log. Two of the five reviewed healthcare records were applicable for a change in custody with one youth have two incidents. Each record

found both youth received a re-screening upon admission utilizing the FEPHS form for all three incidents.

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

The program maintains a written policy and procedures establishing a system whereby all youth shall be oriented to the healthcare system upon admission or the next available opportunity. The health education shall be provided by the healthcare staff, in writing and during an individual session with the youth to ensure youth with identified disabilities can understand the information provided. For youth with cognitive deficits, the teachers in the program shall provide information as to how to present the information to the youth who are impaired. A review of five youth healthcare records validated each youth received a healthcare orientation on the day of admission, as documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for male adolescents. Youth and nursing staff signed the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth received health education throughout their stay documented in the healthcare record. Five reviewed healthcare records supported this practice.

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

The program practice is for the designated health authority (DHA) to be notified by telephone, by text message, or verbally if on-site of all admissions. In addition, when a youth is admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone. Nursing staff document the notification on the DHA Notification of Admission form. The nurse signs the form and the DHA signs the form at the next on-site visit. A review of five youth healthcare records reflected the DHA was notified by telephone and the Notification of Admission form was filed in the practitioner's section of each healthcare record. In addition, the nurse documents the DHA notification on the Nursing Chronological/Notification Progress Note – Male Admission form and the form is filed in the nursing chronological notes section of the healthcare record.

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

The program maintains a written policy and procedures ensuring nursing staff complete the Department's Health-Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). A review of five youth healthcare records supported a new HRH form was completed for each youth within seven days of the youth's admission. Reviewed practice validated the HRH form was completed on the same day of each admission. The nursing staff provided their electronic signature on the HRH forms. The DHA documented a review of the HRH forms on the completed CPAs. An interview with nursing staff confirmed the practice and indicated the HRH is also completed whenever any new significant medical event or change occurs and then annually, thereafter.

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

The program maintains a written policy and procedures ensuring each youth receives a physical health evaluation after admission and prior to any participation in sports, exercise, or any other strenuous activity. The program also maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. A review of five youth healthcare records reflected the program utilizes the Department's standardized Comprehensive Physical Assessment (CPA) form. All CPAs were completed by the designated health authority (DHA). All sections of the CPA were completed in full utilizing "O" with no applicable "X" and included the appropriate medical grade of one through five. All five reviewed CPAs did not complete sections numbers twenty-three, twenty-four, twenty-five, and twenty-six and each documented the youth's refusal with their signature on the CPA. Reviewed documentation confirmed the Department's Problem List was updated for each youth throughout their stay, when applicable. A review of five youth healthcare records supported each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to tuberculosis. In addition, as part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I tuberculosis screening. All tier I tuberculosis screenings were conducted on the day of admission for each youth. Reviewed documentation found the results of the TST were also documented on the Department's Infectious and Communicable Disease (ICD) form, and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. Nursing interviews indicated nursing staff also review the Department's Juvenile Justice Information System to ensure there is a documented TST and to ensure the TST is current and documented as required. The nursing staff also utilizes a tracking log to monitor TST/PPD due dates. There were no youth in the program with symptoms suggestive of active TB. Program procedures outline if the screening indicates the youth has symptoms suggestive of active TB, the youth are not placed in the general population until medically assessed by the DHA.

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). The designated health authority (DHA) shall then decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases / infections. A review of five youth healthcare records reflected each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. Each youth was referred to the DHA for further evaluation and testing was ordered and was performed for each youth. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form for all five youth. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. Nursing interviews confirmed the program's practice. The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV)

infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of five youth healthcare records supported each youth was offered the opportunity to receive counseling and testing for HIV. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. A reviewed of five youth healthcare records reflected two consented for testing; therefore, one additional record was requested and reviewed. The program utilizes the Lee County Health Department to provide pre-counseling, testing, and post-counseling. Reviewed youth healthcare records validated when youth received pre-counseling, testing, and post-counseling, the youth's Health Education Record form was updated. The results were placed in a sealed envelope marked "confidential" with the youth's name and test date documented on the outside of the envelope. Nursing staff interviews indicated the confidential results are given to the youth upon discharge. Nursing staff also maintain a HIV Testing Tracking Log to document the youth's name, Department identification number, date refused testing (if applicable), date of testing, pre-testing date, post-testing date, and provider name. Five interviewed youth indicated they can request HIV testing.

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

The program maintains a written policy and procedures ensuring all youth shall be able to make sick call requests and have their complaints treated appropriately through the sick call system. The program identifies sick call as the official method for a youth to request healthcare services for an illness or injury. Sick call care, including dental complaints, shall be available to all youth. Sick call care is provided by licensed healthcare professionals, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA). The sick call process is intended to provide care in response to complaints of illness or injury of non-emergency nature, but which requires some form of assessment and/or decision-making by a licensed nurse and/or licensed physician. Each youth is oriented to the program's sick call process upon admission. The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist's license expires February 28, 2020 and the optometrist license expires February 28, 2021. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist. The psychiatrist is on-site once a week and meets with the nursing staff, clinical director, and case managers to discuss the needs of the youth and evaluate medication management. The program offers youth the opportunity to make a sick call request, seven days a week, three times daily, conducted by the registered nursing staff. Each day, sick call is conducted from 7:00 a.m. to 8:00 a.m., 12:00 p.m. to 1:00 p.m., and 4:00 p.m. to 6:30 p.m. A review of five youth healthcare records found three youth completed a Sick Call Request form at least once during their stay. The registered nurse (RN) documented the treatment and/or services provided to the youth during the sick call event on the Sick Call Request form. There was one applicable youth who presented a similar sick call complaint three or more times within a two-week period; therefore, two additional applicable health care records were requested and reviewed. The program procedures outlined the healthcare staff will automatically refer the youth to the designated health authority (DHA) for an evaluation and treatment, and documentation validated this practice for all three youth. Reviewed healthcare records indicated

each sick call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed electronically in the program's electronic medical record, as well as the healthcare record. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into a shift supervisor for review. The shift supervisor will determine if the sick call requires immediate attention. The DHA is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. All staff supervisors received medical technician training delivered by the RN. An interview with the RN indicated refresher training is provided annually. The program maintains a sick call box located in the day room hallway mounted to the wall. The box is monitored throughout the day by nursing staff and complaints are triaged for urgency to be evaluated. All youth are seen within twenty-four hours of submission. One sick call was observed with the youth's permission during the annual compliance review. Observations validated the youth was seen by a licensed medical professional in a confidential manner. A youth care worker was positioned outside the Dutch-door to the medical clinic, allowing for privacy. Five interviewed staff indicated nursing staff conducts sick call. Five youth were interviewed and four reported being seen within one day of a sick call request and one youth stated being seen immediately.

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

The program maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. A review of five youth healthcare records found four youth requiring episodic and/or first aid care during their stay in the program. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Nursing staff also maintained an Episodic/First Aid/Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). Nursing interviews confirmed the program's practice. Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Log.

The program also maintains a written policy and procedures ensuring the program-based automated external defibrillator (AED) is properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. The program maintains one automated external defibrillator (AED) located in master control and mounted to the wall. Nursing staff ensure the AED is functioning adequately and include the inspection of the batteries and pads to ensure they are in working order. The AED procedures were observed as audio as demonstrated by the nursing staff. Reviewed AED batteries expire on May 31, 2022 and pads expire on December 31, 2020. Both were last changed on April 19, 2019. The program maintains six first aid kits located in the kitchen, laundry room, master control, medical clinic, van number one, and van number two. An inspection of three first aid kits supported each contained the required items and all items were current and within their expiration period. A list of the items contained in each first aid kit were affixed to the outside of each box with the date of

the weekly inspection along with nursing staff initials. The program also maintains three suicide response kits located in master control, van one, and van two, and observation found each contained a knife-for-life, wire cutters, and needle nose pliers. The first aid kits, AED, and suicide response kits are checked monthly by nursing staff to ensure each are adequately supplied and in operating order. Reviewed training records found all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. Nursing staff maintained current certifications in CPR and AED. Reviewed training records supported shift supervisors have been trained in the administration of the epinephrine auto-injector.

The program conducts announced and unannounced emergency medical drills monthly on each shift. Reviewed documentation supported an annual calendar is maintained identifying the drill conducted. A review of drills conducted for the last twelve months supported drills were conducted monthly on each shift and included CPR/AED demonstration at least quarterly. Observations during the tour of the program found postings throughout the facility informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were located in the administrative office hallway and the medical clinic accessible to staff but inaccessible to youth

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

The program maintains a written policy and procedures ensuring timely referrals and coordination of medical services to an off-site healthcare provider. Evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth healthcare records found one youth requiring off-site care and/or emergency care and two youth who were seen off-site for dental care. Each off-site care event was documented in the healthcare records. The reviewed youth healthcare records indicated each youth was under eighteen years of age and the parent/guardian was notified. The Summary of Off-Site Care Form was completed for each youth and was filed in the appropriate section of the healthcare record. Reviewed documentation supported the DHA reviewed each completed Summary of Off-Site Care Form and discharge paperwork as evidenced by signature and date. One youth required follow-up care and received services as prescribed. An interview with nursing staff indicated the registered nurses track follow-up testing, referrals, and appointments on the Medical Services Tracking form, Physician's Weekly Clinic List Form, and Sick Call/Referral Log Form.

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

The program maintains a written policy and procedures ensuring youth who have been identified with a chronic illness receives regularly scheduled evaluations and necessary follow-up treatment. The purpose of the periodic evaluation is to ensure the youth requiring ongoing treatment or who have experienced changes in condition or treatment regimen are adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of five youth healthcare

records indicated two youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. One additional applicable healthcare record was requested and reviewed. All three youth were classified with a medical grade of two through five. There were two youth currently undergoing treatment for physical health condition which included a body mass index greater than thirty. The program maintains a youth roster and tracking log of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records reflected each youth received periodic evaluations as required. An interview with the designated health authority (DHA) indicated chronic conditions are monitored at least every sixty days and some conditions require more often. An interview nursing staff reported youth identified with a chronic condition are placed on the medical tracking log to ensure the DHA follows-up with each applicable youth. The DHA indicated the nursing staff and DHA meet regularly to discuss important treatment plans for youth. In addition, the DHA indicated formal quarterly meetings are conducted with the facility administrator, nursing staff, clinical director, consultant pharmacist, and DHA to discuss the youth in the program. In an interview, the psychiatrist indicated the youth are evaluated every thirty days. There was no indication of lapses in care or missed periodic evaluations. Reviewed documentation validated each youth received a new Comprehensive Physical Assessment (CPA) within seven days of their admission. Approximately every sixty days the DHA conducts a periodic examination of the youth, and if applicable, continues the youth on the specialized treatment plan and/or modifies the plan. Reviewed documentation supported the Department's Problem List was updated as required.

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

The program maintains a written policy and procedures ensuring medical staff verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medication(s) or order/prescriptions for medication(s), the healthcare staff will conduct a preliminary assessment and interview to determine the medication is verified and documented. Nursing staff complete the Facility Entry Physical Health Screening (FEPHS) to determine medical needs. The signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the present medication(s) and administer the medication(s) as ordered. An interview with nursing staff indicated only a registered nurse completes the admission and any applicable medications are verified with the youth's medical records and the youth's parent/guardian. A review of five youth healthcare records indicated one youth was admitted into the program on prescribed medication. Two additional healthcare records were requested and reviewed. Nursing admission notes documented each youth's current medication and the designated health authority (DHA) Notification of Admission documented current prescribed medication and verbal notification or telephone was noted. Program practice is to notify the DHA for all youth admissions. Reviewed documentation reflected the DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MARs) validated the practice. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. Reviewed documentation reflected all medications have a current, valid order, and are administered pursuant to a current practitioner's order. The program does not utilize restrictive housing; therefore, all medications are administered with consistent practice. Each reviewed youth healthcare record reflected the prescribed medication was continued,

discontinued, changed, or a new medication was ordered. In each instance, the practitioner's order clearly documented the medication and dosage. Oral prescription medications are administered, according to instructions. All staff administering medications shall have knowledge or are informed of the common side effects and precautions of prescribed medications.

Three reviewed youth healthcare records found each youth had a Medication Administration Record (MAR) outlining over-the-counter medications approved through the Authority for Evaluation and Treatment (AET) form. The medication was administered in accordance with the approved protocols and physician's order. All three youth were prescribed medications and reviewed documentation supported the program utilizes a pre-printed pharmacy MAR to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. All three youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. Observations found the medications are procured through a pharmacy. The medications are maintained in blister packs documenting the number of pills in each prescription order. Procured medications are administered by nursing staff. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. Shift-to-shift inventories of controlled medications are conducted by two registered nurses (RN). If there is only one RN on-site, the inventory is completed by the RN and a shift supervisor. All three reviewed MARs supported the youth received the medication(s) as prescribed. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. Nursing staff maintain locked cabinets in the medical clinic with over-the-counter (OTC) medications listed on the Authority for Evaluation and Treatment (AET) form for the trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff are permitted to assist youth in OTC medications when nursing staff are not on-site.

A small amount of OTC medications are stored in the medical cart. If non-licensed staff have been authorized to administer the OTC medication by the RN by phone, the non-licensed staff are given the combination to the key box to open the medical cart. Nursing staff will then change the combination the following morning. There were no indications of lapses and/or errors in the medication administration. A review of the Department's Central Communications Center reports validated there were no incidents of missed medications. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. One youth was applicable for a refusal of medication and it was clearly documented on the MAR and nursing staff completed the Department's Refusal of Treatment form when the youth refused the medication dosage. Observation of one medication administration by nursing staff validated the medication cart was secured when not in use. Observations of the medication cart found it clean and organized with medications separated. The Six Rights of Medication Delivery/Administration was maintained for each youth.

The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. The program had no controlled medications on-site during the annual compliance review week; however, program procedures outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. An interview with the nursing staff validated the practice. The program maintains one refrigerator in the medical clinic for the storage of medication. There was one applicable medication requiring refrigeration during the annual compliance review week which was stored

in the refrigerator. Five youth were interviewed, and four reported not taking any medication. One youth was taking prescribed medication and stated it was administered by nursing staff.

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

The program maintains a written policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Observations found all medications securely stored in the medical clinic inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of over-the-counter (OTC) medications were placed in the locked medical cart for trained authorized non-licensed staff to administer, if needed. Narcotics and other controlled medications are securely stored in the medication cart. The program practice is to store the mediations in a locked box located in the locked medication cart. The program had no applicable youth with prescribed controlled medications during the annual compliance review week. Oral medications were not stored with injectable or topical medications. The program maintains one refrigerator for medications. There was one medication requiring refrigeration during the annual compliance review week and was observed in the refrigerator. The program securely stored sharps and syringes separate from medications. The program maintains a written policy and procedures ensuring all chemical products, medicines, and medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws.

Reviewed documentation and nursing interviews confirmed all OTC medications are inventoried at least weekly. Program practice is for OTC medications to be inventoried using a perpetual daily inventory and verified weekly, usually on Sundays. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses (RN). If there is only one RN on-site, the inventory is completed by the RN and the shift supervisor. Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with a pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires September 30, 2021. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report.

The program maintains written procedures for the disposal of narcotics and other controlled substances. Program practice is for the consultant pharmacist and registered nursing staff to dispose of the medication by placing the medication in an All-Purpose RX Destroyer System bag and document the disposal on the Disposal Log and on the Controlled Medication Inventory Record. All non-controlled medications are sent back to the pharmacy for credit. Observations conducted during the annual compliance review week supported three youth prescribed medications inventories were accurate. Three OTC medications were reviewed, and the inventories were accurate. Three sharps were reviewed, and inventories were accurate. A review of the program's counts from the past six months validated no discrepancies were identified with the counts. The program maintains a current agreement with biomedical waste and treatment company with an operating permit with the State of Florida, Department Health with an expiration date of September 30, 2019.The company picks up medical waste monthly for proper disposal.

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

The program maintains a written policy and procedures ensuring there is an approved plan for exposure control and infection control ensuring staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan / Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Center for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA) federal regulations, and State of Florida guidelines. The plan was reviewed and approved by the facility administrator (FA) on June 9, 2018, and designated health authority (DHA) on July 9, 2018. The plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes Hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan outline outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorist agents, chemical exposures, Methicillin-Resistant Staphylococcus Aureus (MRSA), and other emerging antibiotic-resistant micro-organisms. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program also maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program maintains monthly receipts of medical waste pick-up through Stericycle, Inc. The program maintains a current operating permit through the Department of Health for biomedical waste – state laboratory/clinic with an expiration date of September 30, 2019. The program had no instances in which the Lee County Health Department, CDC, and/or the Department's Central Communications Center (CCC) should have been notified of an infectious disease. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the facility administrator has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility / occupational exposure. The program's Exposure Control Plan/Infection Control Plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards. The plan includes risk assessment and methods of compliance. The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. The plan is accessible to all staff and is maintained in the medical clinic, master control, and in the administrative offices.

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

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

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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 to promote safety and security by maintaining active supervision of youth to include interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing behavior of youth, changing inappropriate behavior, and consistently applying the program's positive performance system. The program conducts formal and informal headcounts throughout the day. A review of the program's logbooks for the past six months verified headcounts and movements are conducted and documented as required. Observation of staff supervision for four days during the annual compliance review included movement from classroom to dormitory, dormitory to recreation, and from classroom to cafeteria. During the observations, staff were actively supervising youth and strategically situated to visibly see youth and respond to any emergency situation. The program has a daily schedule which is posted in the common area and cafeteria. According to the program's contract, staff to youth ratio of one to seven during awake hours was observed to be in compliance. Prior to any movement, staff are informed by way of two-way radio of the count. Once the count is confirmed, youth are moved to the designated area. Random interviews with three direct care staff indicated they were knowledgeable ofwhat the count was without counting and what to do when the count cannot be reconciled.

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

The program has a written policy and procedures addressing the implementation and training of the program's behavioral management system (BMS) which was approved by the facility administrator on July 10, 2017. There were no changes to the BMS since the last annual compliance review. The program has a clearly written BMS which is a multi-level system designed to enhance the youth treatment, increase healthy relationships, pro-social behavior using reinforcing, and decreasing unhealthy behaviors through natural consequences. A review of five staff training records for pre-service training and five staff training records for in-service training, indicated staff were trained on the BMS for pre-service and in-service training. The program has an agreement with the Lee County School District related to the BMS and verified teachers are trained in the implementation of the BMS. Youth are aware of the BMS during orientation. Each youth is provided a program handbook which describes the BMS. A review of

the youth handbooks indicated the BMS is included. A review of five youth records indicated each received an orientation informing the youth of the BMS which includes youth expectations, responsibilities, and consequences. Observation of the facility found the BMS is posted. Observation during school hours and of staff and youth interaction for adhering to the BMS indicated, staff addressed a ratio of four to one positive to negative consequences when redirecting the youth as indicated in the program's policy. An interview with the facility administrator (FA) indicated the program utilizes the Positive Performance System (PPS) to reinforce positive behavior with the youth. The system ensures positive consequences outnumber the negative consequences. The program ensures the rewards outnumber the consequences at a minimum of four to one by posting the daily tracker each day in the dorm for youth to review. Five staff were interviewed and was able to explain the program's BMS and were knowledgeable of the rewards provided to youth. Five staff were interviewed and stated things can be taken away from youth as a consequence such as television, games, and incentives. Five youth were interviewed and were aware of the punishment and consequences used in the program and was able to describe the rewards used in 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 procedures to ensure staff are provided feedback regarding the implementation of the behavioral management system (BMS). Review of the BMS indicated the BMSis not used solely to increase a youth's length of stay, deny basic rights or services, promote the use of group punishment, allow youth to punish other youth, or include disciplinary confinement. The program includes a process during weekly treatment team meetings for staff to explain to the youth the reason for any imposed sanctions. Youth are given an opportunity to explain their behavior during the treatment team process. Special treatment team meetings are held for youth whose behavior need immediate intervention. The program does not utilize room restriction for major infractions. A random review of five staff job descriptions indicated BMS implementation is addressed as a part of the staff's daily functions. The program has an annual in-service and pre-service training plan which includes the BMS for all staff. The program has an agreement with the Lee County School District related to the BMS and verified teachers are trained in the implementation of the BMS. A review of five staff in-service and five staff pre-service training records found staff are being trained on the BMS. An interview with the facility administrator (FA) indicated the BMS is monitored to ensure staff utilize the four to one ratio to promote positive behaviors. The FA also indicated the treatment team discuss all consequences to ensure there is a therapeutic approach to deterring negative behaviors as opposed to an initial loss of privileges. According to the FA, the BMS is monitored to ensure it is administered fairly and consistently among all staff by having each department staff attend special treatment team meetings to ensure the BMS guidelines are completed as intended. Five youth were interviewed and four stated staff are consistent in the use of rewards. One youth stated not all staff are consistent in the use of rewards by indicating some staff do

not give rewards while other staff do, even if the reward is supposed to be given. Five staff were interviewed and stated youth are informed of the consequences and can explain their behavior. Five staff were interviewed and stated supervisors provide feedback to staff regarding the implementation of the BMS by having one on one sessions, during morning briefings, verbal coaching, and during the annual performance evaluation.

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 policy and procedures in place for staff to conduct and document ten-minute checks. The program has a total of thirty-one recording video cameras with each being operable and capable of recording thirty-days of video footage. Staff are required to document room checks every ten-minutes when youth are in their sleeping quarters. Staff are to ensure skin or a body part is seen to confirm the youth's presence and are not allowed to enter a youth's room. Staff will document the actual time of the room check and initial on the ten-minute check log sheets verifying who completed the room check. An "X" is marked in the box for the time of the room check for rooms which do not have a youth in the room at the time of the check. Supervisors are required to conduct three room checks and visibly see flesh of each youth in their room. Supervisors then document in red, on the ten-minute log sheets to include the time of the check and the supervisor's initials. A review of ten-minute check logs of two shifts from six different days and six different times along with the corresponding video footage indicated, checks were consistently conducted and documented in real time as required. Five staff were interviewed and each stated room checks are conducted every ten-minutes when youth are placed in their rooms for sleeping or non-punishment reasons.

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

The program has a written policy and procedures to track the daily census. The program tracks daily census information to include the daily count, new admissions, releases, youth temporarily away from the program, transfers, and direct discharges. Youth are accounted for at all times by

a physical count and a random headcount. Random review of the program's logbooks for the past six months contained documentation of youth counts at the beginning of each shift, after outdoor activities, and movement from school and groups. Documentation in the logbooks also included youth temporarily away from the program, missed counts, emergency counts, and reconciliation of the count. The program maintains an approved escape response plan signed by the facility administrator and the designated safety and security coordinator on August 7, 2017 to ensure appropriate levels of supervision is maintained to provide adequate safety and security which is necessary to prevent escapes. The program's escape response plan is reviewed with staff to ensure the procedures are followed in the event of a youth escape. Observation of youth count during the annual compliance review indicated prior to any youth movement, staff are informed of the number of youth being moved and to what location. Random interview with staff indicated when the count is not reconciled all movement stops and an emergency count is conducted. Five staff were interviewed and was able to explain when youth counts are conducted and what happens when there is a discrepancy, including emergency counts.

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

The program has a written policy and procedures for logbook documentation. The program maintains a bound logbook with numbered pages which documents emergency situations, incidents, population counts, perimeter checks, transports, removal of youth from population, admission, releases, and calls to the Department's Central Communications Center (CCC) and Florida Abuse Hotline. Supervisors can leave special instructions pertaining to supervision of youth. Each entry is made in ink with no erasures or white-out. The program conducts staff briefings prior to the beginning of each shift and is documented in the logbook. Incoming staff are briefed on the previous shift and sign the logbook to acknowledge the information has been shared. A review of logbooks for the past six months indicated the required documentation is entered; however, errors are not consistently struck through with a single line and are not initialed by the staff correcting the error. Review of the logbooks also confirmed all internal incidents were reported to the Florida Abuse Hotline and the CCC.

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 for assignment, inventory, tracking, and storage of program's keys. The program maintains a master key inventory of all active and un-issued keys which are stored in a box and remains locked when not in use. Keys are bound on a tamper resistant color-coded ring. Once staff arrive to work, they gain access to the program

by way of the administration office. Staff submits their personal keys, receive a program key from the supervisor, and sign the key control log indicating a program key has been assigned. Personal keys are placed in the key box in the space where the assigned program key was stored. Medical staff have a separate key box located within the main key box with medical staff access only. Once medical staff report to work, they obtain the program key, deposit their personal keys in the medical key box, and sign the key control log. At the end of the shift staff return the program keys, receive their personal keys, and sign the key control log indicating the program keys have been returned. Damaged keys are turned over to the physical plant manager to have the key replaced. The program is currently without a physical plant manager who resigned on August 22, 2019; however, the assistant facility administrator (AFA) has assumed the duties until a new physical plant manager is hired. The program also has a list of staff who are assigned permanent keys. Permanent keys are issued and staff signs an acknowledgment form indicating a key identification number and the number of keys issued. A random check of three staff found there were no staff with personal keys on their person. An interview with the AFA indicated, there were no lost keys reported in the past six months. If any keys are lost, staff indicated all program movement is stopped and a search is conducted. If the keys have not been found within two hours, a report is made to the Department's Central Communications Center (CCC). Five staff were interviewed and was able to explain the program's key control process including how keys are assigned, reconciled, the process for missing or lost keys, damaged keys, and restricted keys.

5.08 Contraband Procedure	**Satisfactory Compliance**

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

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

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

The program has a written policy and procedures which identifies a list of unauthorized and illegal contraband and how to dispose of illegal contraband. All illegal contraband is turned over to law enforcement. Youth are notified through the program's youth handbook of unauthorized and prohibited contraband and the consequences of possessing contraband. Visitors are also notified of unauthorized and prohibited contraband during visitation. A review of the program's policy, youth handbook, and visitor contraband list verified a list of unauthorized items not permitted to include personal cellular telephones or devices capable of taking photos and/or audio/video recordings. The program conducts searches of rooms on each of the three shifts and documents on a daily search report any contraband found. All incoming and outgoing mail are screened by administration and/or the case manager for contraband. A random review of

the search reports indicated staff were not consistently documenting how contraband was disposed. A review of the program's logbooks for the past six months indicated perimeter and facility ground searches are documented in the logbook. A random review of daily search reports verified this practice. A review of reports submitted to the Department's Central Communications Center (CCC) for the past six months indicated illegal contraband was confiscated on one occasion. In this instance, the contraband was discarded as required. An interview with the facility administrator (FA) indicated the program has a system to prevent the introduction of contraband by searching staff and visitors upon entry into the program. Youth and staff are informed of what items are considered contraband and the associated consequences. Upon discovery of any contraband, the assistant facility administrator (AFA) is informed of the contraband item and it is discarded appropriately.

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 to ensure searches and full body visual searches are conducted according to Florida Administrative Code. Youth are searched at the time of admission, after off campus activity, before and after each youth movement, and visitation. Searches are conducted by two staff of the same gender as the youth being searched and are conducted in a private area. Parent/guardians are notified of searches during visitation by way of the parent intake letter which is sent at the time of the youth's admission. Youth are searched after school, after transport, group, outdoor recreation, and meals. Youth who are a new admission, re-admission, returning from visitation, returning from off campus activity, suspected of contraband, or a security risk are searched prior to returning to the general population. Observation of searches was conducted of youth after school and after group indicated searches are conducted by staff of the same gender, conducted in a manner not to degrade the youth, based on the Protective Action Response (PAR) training manual, and reflect trauma informed practices. Youth are advised of the search process and the basis for the search. Five staff were interviewed and was able to explain how youth searches are conducted. Five youth were interviewed and indicated searches are conducted by a male staff when returning from off campus, after outdoor activities, when items are missing, after visitation, after meals, and after work detail

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

The program has a written policy and procedures to ensure vehicles used to transport youth are properly maintained in working order. The program has two operable vans to transport youth. A review of automotive vehicle invoices and vehicle inspection logs validated each vehicle received an annual safety inspection and required maintenance; with documentation of services completed on each vehicle. Both observed vehicles are equipped with an up-to-date fire extinguisher, first aid kit, a seatbelt cutter, window punch, and operable seatbelts for each

passenger. First aid kitsremain inside the administration area until the vehicles are in use. The inspection of one van found the door to the youth passenger area was accessible from the inside; however, the program's policy requires use of restraints and a staff person in addition to the driver seated next to the restrained youth in a vehicle where the rear doors are inoperable from the inside. The remaining vehicle was observed not to open from the inside. A transport was unable to be observed during the annual compliance review period; however, informal interviews with youth and staff indicated seatbelts are worn during all transports by youth and staff. Random observation of ten staff vehicles indicated each were locked. A check of each transport vehicle found each vehicle was locked when not in use.

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

The program has a written policy and procedures to ensure the safe secure transportation of youth and staff. The program has two operable vehicles to transport youth. Inspection of both vehicles verified an up-to-date fire extinguisher, first aid kit, seatbelt cutter, and window punch. First aid kits remain in the administration area until ready for use. The program has one vehicle where the rear passenger doors cab is accessible from the inside. The remainingvehicle doors are not able to be opened; however, the program's policy requires use of restraints and a staff person in addition to the driver seated next to the restrained youth in a vehicle where the rear doors are inoperable from the inside. The program maintains a list of staff who have eligible driver's license which is updated monthly. A review of the list for the past six months indicated driver license checks are conducted monthly. The program also provides a ratio of one staff to five youth during transport. Transporters are provided a fully charged cellular telephone to communicate during emergency situations. Five staff were interviewed and stated cellular telephones and two-way-radios are provided during transport. Five youth were interviewed and each verified staff are not allowed to transport youth in their personal vehicles. Random observation of ten staff vehicles indicated each were locked. An observation of a transport during the annual compliance review was not able to be conducted.

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

The program has a written policy and procedures to ensure safety and security of the program is maintained. The policy addressed who is responsible for conducting the audits, procedures to implement corrective actions for deficiencies, and an internal system to verify deficiencies are corrected. Weekly safety and security audits are conducted by the facility administrator (FA) and documented on the Safety and Security Audit Inspection form. Deficiencies are addressed on the form and a work order is submitted to the appropriate staff for corrections. Deficiencies are also discussed during the morning managers meeting. Review of the Safety and Security Inspections forms for the past six months indicated inspections were completed weekly as required. Supervisors also conduct perimeter checks on each shift and are documented in the program's logbooks. A review of the program's logbooks for the past six months verified checks are conducted as required. An interview with the facility administrator (FA) indicated the program conducts weekly safety and security inspections and provide the feedback to the Department.

5.13 Tool Inventory and Management	Limited 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 for tool management. The policy addresses storing and inventory of tools as well as class type. The program is currently without a physical plant manager since August 22, 2019. The facility administrator (FA) and assistant facility administrator (AFA) are maintaining the inventory when tools are in use. The program maintenance tools are stored in the maintenance shop located outside the facility and a daily tool inventory is maintained on each tool when the shop is in use. Tools are classified as class A and B and are labeled with an inventory number and are inventoried daily. The program maintains a tool inventory list with each tool identified by the corresponding inventory number and name of the tool. A review of the inventory list for the past six months indicated the tools were being inventoried; however, from August 23, 2019 to August 30, 2019 the program did not conduct a tool inventory. As of September 1, 2019, the program resumed daily inventory of tools. Observation of the maintenance shop indicated it was clean and neat. Kitchen knives are stored in a locked cabinet inside the kitchen pantry with limited access to kitchen staff. Observation of kitchen tools indicated there was no perpetual inventory daily of class A kitchen tools for the past five months. As of September 17, 2019, an inventory list was created and resumed the daily inventory of kitchen knives. There were two damaged kitchen knives being stored. This was brought to the attention of the facility administrator, and the damaged tools were removed while on-site. A review of five staff in-service training records found staff to be trained on class A and class B tools. Five youth were interviewed regarding which tools youth can use in the program. Each youth reported mops and brooms. Three of the five youth reported they are also allowed to use scrub brushes.

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 for youth tool handling and supervision. A storage closet adjacent to the kitchen is used to store class B tools which is accessible to staff. Youth are only allowed to use class B tools. Youth are not allowed to handle tools unless a risk assessment has been completed and determining the youth is not at risk. Youth searches are conducted after each activity involving the use of tools. The staff-to-youth ratio during work details is one-to-five. An observation of work projects was unable to be conducted during the annual compliance review. A review of five youth case management records verified risk assessments are completed during treatment team and identify if a youth is eligible to handle tools for work detail. A review of five staff in-service training records indicated each were trained in the use of class B tools. Five youth were interviewed and stated they can use mops, brooms, and scrub brushes. Five randomly selected staff were interviewed and each reported youth can use mops and brooms. One of the five staff also stated youth can use scrub bushes and rakes.

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 establishing guidelines for outside contractors who come on-site to complete repairs. All outside contractors are required to sign the visitors sign-in log, are provided a Visitor's Contraband form outlining unauthorized items, and must review and sign the contractor guidelines. Approval by the facility administrator (FA) or designee must be obtained if any unauthorized items are needed by the contractor while at the program. Any tools required to be used within the program is inventoried and recorded on the contractor's form before and after any repair are completed. A random review of the contractor sign-in sheets and the outside contractor's forms along with the corresponding work invoices verified the contractors were on-site on the same date the documents were signed. Each contractor's form contained an inventory of the tool used for the repairs. An interview with the assistant facility administrator (AFA) indicated when contractors are on-site, youth are not allowed near the work area. A staff is assigned to the contractor to ensure the work is being competed and all tools are accounted for every time a contractor is on-site.

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's Continuity of Operations Plan (COOP) which addresses fire, safety, and evacuation emergency drill are to be conducted monthly on each shift at random times and under varied conditions. Drills are documented on the program's facility drill form which indicates the type of drill, date and time of the drill, participants, a brief scenario, and recommendations. A review of the program's facility drill forms from the past six months verified drills were performed on each of the three shifts and included all staff on duty. The forms also included debriefing documentation and feedback on how the drills were performed. Observation of the program during the annual compliance review indicated, egress plans are posted throughout the program and each fire extinguisher was tagged and had a current fire inspection. Five youth were interviewed and each indicated fire drills are conducted at least monthly and they have been instructed on what to do in case of an emergency. Five staff were interviewed and stated in the past twelve months they participated in weather, bomb threat, terrorism, escape, and fire drills. An interview with the facility administrator (FA) indicated drills are conducted monthly and include medical, fire, suicide, chemical spill, active shooter, escape, flooding, hurricane, lightening, bomb threat, and hostage situations.

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

The program maintains a written policy and procedures regarding the Continuity of Operations Plan (COOP). The program's COOP identifies a coordinated disaster plan. The plan provides for a continuity of mission essential functions across a wide range of potential emergency situations. The COOP also addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. A review of the COOP confirmed the plan was submitted to and approved by the Department of Juvenile Justice Residential Services regional director on May 17, 2019 and contains a plan for alternative housing, maintains a hard-copy of critical identifying information on each youth in the program, and readily accessible in the event an emergency situation arises resulting in relocation. An interview with facility administrator (FA) indicated a copy of the COOP is maintained in the FA office, assistant facility administrator's (AFA) office, and in the administration office.

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

The program has a written policy and procedures for the storage and inventory of flammable, poisonous, and toxic materials. Toxic materials are stored outside the facility in the locked maintenance shed. A list of staff who are authorized to use chemicals is posted on the inside of the maintenance storage door. All caustic materials are stored according to type and use. A safety data sheet (SDS) binder is located inside the storage area with a picture of each material corresponding to the SDS. A perpetual chemical inventory list is maintained and the chemicals are checked daily. The program's physical plant manager who resigned on August 22, 2019 was responsible for the inventory of materials; however, since the physical plant manager departure, the inventory of chemicals was assumed by the assistant facility administrator (AFA). A review of the inventory list for the past six months verified this practice as well as the inventory combined with the appropriate SDS. Chemicals used in the kitchen are stored in the kitchen's supply room. Each chemical has a SDS and inventory log. Observation of the SDS and inventory logs verified the chemicals matched the inventory. Observation of the storage areas indicated the chemicals were neatly stored and securely locked with limited access

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

The program has a written policy and procedures to ensure youth do not handle poisonous, flammable, and toxic items and materials. Authorized staff maintain control over all flammable, poisonous, and toxic items with limited access. Youth do not have access to these items. Authorized staff will obtain a supply of chemicals from the maintenance shed when needed. Review of the logs verified staff sign out chemicals when in use. Youth are not allowed to possess flammable, poisonous, toxic and caustic items. Staff will spray the cleaning chemical and youth will wipe it up when needed. Youth are not permitted to clean any chemical spills, handle, or dispose of any person's biohazardous human waist. Five youth were interviewed and each stated they do not handle any chemicals. One of the five youth reported they painted walls in the program.

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

The program has a written policy and procedures to ensure all flammable, toxic, caustic, and poisonous items are disposed appropriately. All unused hazardous materials are storedin the locked storage shed located off campus and are disposed according to the safety data sheet (SDS). The program's physical plant manager resigned on August 22, 2019 and was responsible for ensuring chemicals were disposed of according to the Occupational Safety and Health Administration (OSHA) standards; however, since the physical plant manager departure, the inventory of chemicals was assumed by the assistant facility administrator (AFA). A review of the chemical inventory log indicated materials were disposed of by the FA who is trained in disposal of hazardous items and toxic materials. Further review of the logs indicated when the materials were disposed and the means of disposal. Used kitchen grease and waist is stored in a large container outside the kitchen area. The program has a contract with Darling Ingredients Incorporated to dispose of used grease. According to the FA, the program has not used grease to cook food and has not disposed of kitchen grease since the last annual compliance review. All chemical spills are reported immediately to the shift supervisor. An evacuation of the affected area is conducted and a determination is made by the FA whether to contact outside assistance to contain the spill. Staff and youth are not allowed to return to the affected area until it has been deemed safe by a qualified professional. An interview with the FA indicated, the program

disposes of chemicals at the Lee County Solid Waste Department to ensure OSHA requirements are met. There were no incidents of chemical spills at the program within the last six months.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures for youth to have visitation and communication with family members to re-establish family and community relationships. Youth are informed of visitation upon admission during the orientation process. The program encourages visitation from the parent/guardians by forwarding a welcome letter upon the youth’s admission, notifying the days and time of visitation, who is allowed to visit, and the corresponding rules of visitation. A list of authorized visitors and correspondence is maintained in the youth’s case management records and updated as needed. The program also maintains a visitation binder which includes the youth face sheet, picture identification of the authorized

visitor, and visitor signatures. Visitation is held in on Saturdays and Sundays from 1:00 p.m. to 3:00 p.m. Special visitations are also provided for those parent/guardians who are unable to participate on the regularly scheduled visitation day. A review of the program's logbooks for the past six months verified visitation and special visitation are conducted as required. Youth are also provided weekly telephone calls, writing material, and a self-addressed stamped envelope to mail letters to approved family members. Youth have unimpeded access with the courts, attorneys, the Department of Juvenile Justice probation officer, and/or the Department of Children and Families case worker. Observation verified the visitation and telephone schedules were visibly posted in the youth's living area. A review of five youth case management records verified each record contained an approved correspondence, visitation, and telephone log. Five youth were interviewed and each indicated they were given the opportunity to communicate with family members by mail, telephone, and/or visitation.

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

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

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

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

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

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

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

The program has a written policy and procedures to ensure each youth has a safety plan. Plans are developed to identify warning signs, youth baseline behaviors, crisis recognition, coping strategies to include people and health environments, intervention strategies, and debriefing preferences. A review of five youth case management records indicated each youth initial safety plan was jointly prepared with the youth, parent/guardian, clinical staff, and contained the required topic areas. Each reviewed plan incorporated recommendations form collateral sources

and previous clinical assessment. Each safety plan was reviewed monthly during treatment team meeting, signed by staff who have contact with youth, and updated as required. Five youth were interviewed and each stated they were involved in the development of their safety plan.