STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Gulf Academy
TrueCore Behavioral Solutions, LLC
(Contract Provider)
765 E. St. Johns Avenue
Hastings, Florida 32145

Review Date(s): February 26 - March 1, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Patrick M McKinstry, Office of Program Accountability, Lead Reviewer (Standard 1)
Jessica Gibson, Office of Programming & Technical Assistance, Technical Assistance Specialist (SPEP)
Darrell Johnson, Detention, Chief Detention North (Standard 5)
Jillian Lewandowski, Office of Program Accountability, Regional Monitor (Standard 3)
Mike Marino, Office of Program Accountability, Regional Monitor (Standard 4)
Meghan Thrasher, Probation, Juvenile Probation Officer Supervisor (Standard 2)
Carlos Valdes, Associated Marine Institute, Executive Director (Interviews)

Program Name: Gulf Academy
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: St. Johns County / Circuit 7
Review Date(s): February 26 - March 1, 2019

MQI Program Code: 1068
Contract Number: R2104
Number of Beds: 56
Lead Reviewer Code: 144

Methodology

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

Persons Interviewed

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

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Gulf Academy program is a non-secure residential commitment facility for males between the ages of twelve to nineteen. The program is located in Hastings, Florida and operated by TrueCore Behavioral Solutions, LLC through a contract with the Department. The program is co-located with Hastings Comprehensive Mental Health Treatment Program/Substance Abuse program under the same contractual agreement. There is combined management team shared between the Gulf and Hastings programs. The program provides services to youth males who are identified in need of intensive mental health services and medical overlay services. In addition, the program fosters each youth by providing them with Teen Relationship workbook, Living in Balance, Life Skills #225, Individual Therapy, Young Men's Work, Anxiety Workbook for Teens, Anger Management, and Thinking for Change (T4C) curriculum. Program administration is comprised of a facility administrator, three assistant facility administrators, health services administrator, business manager, youth services advocate, dietary manager, director of clinical services, assistant director of clinical services, director of case management, transition services manager, and a physical plant manager. The program has two licensed psychiatrist who are required to be on-site one day each week for sixteen hours each week and on-call twenty-four hours a day, 365 days a year. The designated mental health clinician authority (DMHCA) is a licensed psychologist with a clear and active license in the State of Florida. The DMHCA is on-site forty hours a week and on-call as needed, in the event of a mental health or substance abuse emergency. The DMHCA supervises the assistant clinical director, which was vacant the time of this annual compliance review. The program provides medical services twenty-four hours each day. There are six registered nurses (RN) employed for both Gulf and Hastings program. The program contracts with an osteopathic physician (DO) to serve as the designated health authority (DHA). The DHA is available, twenty-four hours each day, seven days a week. The DHA oversees all health-related services provided at the program, to include but not limited to the review of written medical policies and procedures, review of youth healthcare records, completion of Comprehensive Physical Assessments and follow-up care, as needed. There is a contract in place with another DO to provide coverage for the DHA if unavailable to be at the program. Educational services for youth are provided by the St. Johns County School Board. The program has one hundred ninety-two cameras in which one hundred seventy-nine were operational. The program has sub-contract with Village Key to repair the thirteen cameras which were not operational. At the time of the annual compliance review, the program had reported the following number of vacant positions: twenty-one youth care worker Is, two youth care worker-II YCW II), four therapists, one maintenance worker, one assistant clinical director, two case managers, one assistant facility administrator of security, one certified behavioral analyst, and two master control technicians. The program reported having nine YCWs, one case manager, and three therapists who were in training during the time of the annual compliance review. At the time of the annual compliance review, the program was under an outcome based corrective action plan and an admission freeze due to the excessive number of vacant positions.

Standard 1: Management Accountability

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

A review of forty-one staff records were required and eligible for an initial background screening. Thirty-nine staff records revealed a background screening was completed prior to the staff's hire or becoming a volunteer. The remaining two staff were placed into the program's orientation and training program, having no contact with youth. On rare occasions the program may not have received the initial background screening back from the Department's Background Screening Unit (BSU); however, will have the staff start orientation and training. These staff will be assessed once the background screening is returned from the BSU. Observation of the training class confirmed both staff members were participating in the orientation class. None of the thirty-nine staff background screenings required an exemption prior to working with youth. One staff was rehired and had a break in service, as indicated within the staff verification system (SVS). Thirty-five staff had a pre-employment assessment tool and all thirty-five received a passing score. The results were documented in each of the staff's employment records. The remaining six staff were awaiting the results of their assessments and were attending the program's orientation and training program. Observation of the training class confirmed the six staff members were participating in the class. The program utilizes the Ergo Metrics Juvenile Corrections Testing System as their pre-employment assessment tool. Hastings and Gulf Academy under TrueCore Behavioral Solutions adds each employee /volunteer to the clearinghouse employment roster. The program assesses each potential candidate to the program by reviewing the Department's Central Communication Center (CCC) person involvement history report, the SVS module, and the Florida Department of Law Enforcement (FDLE) automated training management system (ATMS) results. The program's practice is to have a staff member present and in the line of sight for a volunteer, mentor and/or intern who is assisting or interacting with the youth on an intermittent basis for less than ten hours a month., This practice was observed during the annual compliance review. The program had a coach and two players from the Duval Raiders arena football team on-site to participate in the program's monthly youth award ceremony. The three visitors were observed being monitored by the program staff as they interacted with the youth during the award ceremony. The program does not currently have a person who assists or interacts with youth on an intermittent basis for less than ten hours and may have access to confidential information. An Annual Affidavit of Compliance with Level 2 Screening Standards was completed, sent, and signed to the Department's BSU on December 3, 2018. Teachers who are paid by the school board or funding provided by the school board or Department of Education received an annual screening on December 3, 2018.

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

A review of the program's employee roster indicated there were eight staff eligible for a five-year background re-screening. Each of the staff member's five-year re-screenings were completed every five years, which was calculated from the staff member's agency hire date. Each of the eight background rescreening's were submitted to the Department's Background Screening Unit (BSU) Clearinghouse at least ten business days prior to the staff member's five-year anniversary date. The program did not have volunteers, mentors, and/or interns who required a five-year re-screening since the last annual compliance review. The program has a written facility operating procedure (FOP) which addresses the program's practice for five-year re-screening.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.* • *All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline.* • *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.* • *The environment is free of physical, psychological, and emotional abuse.* • *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety.*	

The program had a total of thirty-five Central Communication Center (CCC) calls since the last annual compliance review. Seven of the thirty-five reviewed CCC incidents were allegedly related to physical, psychological, or emotional abuse. Two of the seven reviewed CCC incidents were found with substantiated findings related to physical, psychological, or emotional abuse. Five staff personnel records were reviewed for adherence to the code of conduct. Each of the five staff personnel records had a signed code of conduct. During the annual compliance review, a tour of the facility and on-site observations found postings of the telephone numbers for the Florida Abuse Hotline and the CCC for youth eighteen years of age and older. The program has a written facility operating procedure (FOP) which addresses incident reporting requirements and child abuse reporting procedures. All staff at Gulf Academy will immediately report any knowledge or suspicion regarding an incident of abuse or harassment which has

occurred in the program to the Florida Abuse Hotline and the CCC for youth eighteen years of age and older. A youth's refusal to make the abuse call does not relieve the staff from being mandated to call the abuse hotline, if the staff has reasonable suspicion abuse has occurred. Staff will verbally notify the on-duty supervisor once the call to the Florida Abuse Hotline or the CCC has been completed and provide the reason for the call. Staff will complete an internal Incident Report form and forward the completed form to their assigned supervisor once the call has been made to the Florida Abuse Hotline or the CCC. This process is not required if the person made an anonymous report relating to sexual misconduct and wishes to remain anonymous. All staff will provide youth with timely telephone access to report allegations of abuse without intimidation or retaliation. Staff should never prevent a youth from self-reporting or making a call to the Florida Abuse Hotline or to the CCC. In addition, staff will not prohibit youth in controlled observation from making an abuse call; however, the call may be delayed until the youth is calm and compliant with program rules. Documentation of any delay reporting abuse based upon behavior is documented on an internal Incident Report. Staff will verbally immediately notify the shift manager of a youth's request to contact the Florida Abuse Hotline or the CCC . The shift manager will attempt to immediately notify the assistant facility administrator (AFA) or the administrative duty officer (ADO); however, notification is not required in order to proceed with the youth's request to contact the Florida Abuse Hotline or the CCC. The shift manager will assist the youth in making the call by dialing the appropriate telephone number, document the date and time of the call, document the operator's name and number, and provide this information on the internal incident report. The shift manager will allow the youth to communicate freely with the Florida Abuse Hotline operator, maintain sight contact of the youth, and remain in an area which allows the youth to freely and confidentially report the abuse. The youth is not required to communicate with anyone as to why they made the call. The shift manager will have the youth complete and sign a refusal form if prior to making the call the youth changes their mind and decides not to make the call. If the youth refuses to complete or sign the form, the shift manager will ensure the youth's refusal of the call is documented in the facility logbook. If the youth decides not to make the call but the staff knows or has a reasonable suspicion the youth has been abused or neglected, the staff shall make an abuse report to the Florida Abuse Hotline or the CCC, as appropriate. The shift manager will forward the refusal form to the AFA prior to the end of the shift. In addition, complete an internal Incident Report which documents the youth's statement and statements from other observers in the event an incident of abuse or neglect by a staff member is witnessed, suspected, or reported by a youth. The shift manager will forward all information to the AFA or place the information in the AFA mailbox, if after hours prior to leaving at the end of their shift. The (AFA) or ADO will complete the appropriate notification to the CCC and the regional director(RD). In addition, document the notifications on the applicable internal Incident Report form. The FA will inquire in the daily management meeting if there were any requests from youth to report abuse or were there any actual abuse calls made and document the findings on the daily morning management meeting minutes. The FA will forward all paperwork related to the allegations of suspected or known sexual abuse which falls under the prison rape elimination act (PREA) requirements to the PREA corporate coordinator for review and record maintenance. The paperwork shall include the incident report, supplemental statements, date and time of contact with the abuse hotline and law enforcement, and any other documents which are pertinent to the case.

Seven youth were interviewed and five stated they felt safe in the program. Two youth stated they did not feel safe in the program. When asked the youth to follow up on their response, the youth stated sometimes the staff appears aggressive and staff treats the youth bad by placing their hands on the youth. The youth further stated, staff use the protective action response (PAR) on the youth for no reason and will put things on the youth's head for the other youth to beat them. Five youth stated they were never stopped from reporting abuse to the Florida

Abuse Hotline or the CCC (if eighteen years of age or older) since they have been at the program. Two youth reported being stopped from calling the Florida Abuse Hotline. One youth said they tried calling because of staff to youth ratio, the youth uniforms not being washed for a few days, and the quality of the food was horrible." The other youth stated, staff did not allow the youth to call the Florida Abuse Hotline due to the youth had not taken a shower for several days. Both youth was asked during the interview if they wanted to call the Florida Abuse Hotline and both youth declined. Each of the seven youth were asked if staff are respectful when talking with them and other youth. Four stated staff are respectful when talking with them or other youth. Four of the youth stated the staff does not use profanity and talks to them in a respectful manner. One youth reported staff sometimes speaks aggressively towards the youth. Another youth replied occasionally staff argues with the youth and cannot handle their composure. One youth reported staff are not respectful when talking with youth. The youth further stated the staff will tell youth they will beat them up. Three of the seven interviewed youth stated never hearing staff use profanity when speaking with them or other youth. Three other youth reported they heard staff occasionally use profanity. One youth reported hearing staff use profanity often. A meeting was held with the program, the corporate management team, and the lead staff of the monitoring and quality improvement team to openly discuss the areas identified concerning the youth responses relating to the abuse-free environment. The program was deeply concerned and immediately put into place action steps to address the issues. The program will address the staff who were overly aggressive with youth, a written warning will be provided, and staff will be required to read and re-sign the employee handbook, with specific focus on infractions. The program will obtain youth input concerning staff at the program by implementing a new youth survey. The youth survey will be created and administered during one-on-one listening sessions with each youth in Gulf Academy. The results will be utilized to make program improvements. In addition, the program will conduct at a minimum monthly community dormitory meeting with the youth. Each of these areas will be implemented or completed by March 8, 2019.

Three staff were interviewed and were asked to explain the process for allowing staff and youth to call the Florida Abuse Hotline or the CCC to report suspected abuse. All three staff were able to explain the process necessary for making contact to the Florida Abuse Hotline or CCC. Each of the three interviewed staff denied ever observing a co-worker denying a youth the opportunity to call the Florida Abuse Hotline. All three interviewed staff denied observing a co-worker use profanity, threats, intimidation, or humiliation when interacting with youth.

The facility administrator (FA) was interviewed and asked what is included in the program's employee code of conduct and the actions taken if physical abuse, threats, or profanity towards the youth is used. The FA indicated the employee code of conduct addresses items such as proper dress code, call out policy, and the disciplinary process. The disciplinary process includes a breakdown of minor, major, and critical infractions detailing a matrix of consequences such as coaching, written warning, suspension, and termination. The FA was asked to explain the program's incident reporting process. The FA indicated anytime there are situations such as program disruptions, escape/abscond, medical incidents, mental health and substance abuse, abuse, etc. , the program notifies the Department's CCC within two hours of the incident occurring. All youth have unhindered access to make an abuse call and it is the responsibility of the staff to respond as quickly as possible to these types of request.

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

The program had a total of thirty-five Central Communication Center (CCC) calls since the last annual compliance review. Seven of the thirty-five calls were related to physical, psychological, or emotional abuse. A total of five incidents were reviewed and two of the five incidents reviewed were found with substantiated findings related to physical, psychological, or emotional abuse. The program provided their internal investigations into each of the five reviewed incidents . The documentation provided supports the efforts made by management to take immediate action to address all alleged incidents related to physical, psychological, or emotional abuse. An interview with the facility administrator (FA) was conducted on how the program ensures staff and youth are knowledgeable on contacting the Florida Abuse Hotline and the CCC, how the program tracks these type of calls, and how are the results of the reports are incorporated into management meetings. The FA indicated all staff receive annual training on the incident reporting process, in addition to the training the Florida Abuse Hotline and the CCC numbers and the youth rights to live in an abuse free environment are posted throughout the facility and in the youth living quarters. For tracking purposes the Florida Abuse Hotline and the CCC incidents are discussed during the morning meetings, a CCC report is sent out daily and a CCC tracker is sent out weekly. The FA indicated there were six disciplinary actions taken due to the allegations of abuse towards a youth since the last annual compliance review.

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

The program had a total of thirty-five Central Communication Center (CCC) calls since last annual compliance review. A sample of five reports were reviewed and four were reported to the CCC within two hours of the program becoming aware of the incident. One of the incidents was reported eleven minutes late. A review of the program's logbooks revealed each of the five CCC incidents were documented. There were no indications of internal incident reports and/or grievances which should have been reported to the CCC. The program had an increase in the total number of reportable incidents to the CCC since the last annual compliance review. The facility administrator was asked to explain the program's incident reporting process. She stated, for tracking purposes, CCC/Florida Abuse Hotline incidents are discussed during every morning meeting and a CCC report goes out daily, and a CCC tracker goes out weekly.

1.06 Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory Compliance

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

A total of five protection action reports (PAR) interventions were reviewed. Four PAR intervention reports were completed by the end of the staff's workday. One of the five PAR reports was completed two days late. Each of the five PAR reports included statements from all staff involved. None of the PAR interventions required the use of mechanical restraints. One of the five PAR interventions resulted in an injury to a youth which was reported to the Department's Central Communication Center (CCC) within two hours. One of the reviewed PAR interventions resulted in an allegation of abuse by the youth. A review by a PAR certified instructor or supervisory staff was completed for each of the five PAR interventions reviewed. One of the five incidents indicated the PAR medical review was necessary due to a laceration as a result of a takedown by staff. All five PAR interventions contained a post-PAR interview with the youth which was conducted by the facility administrator (FA) or designee. The post-PAR interview was no longer than thirty-minutes after the PAR intervention. All five PAR intervention reports were reviewed by the FA or designee within seventy-two hours of the incident. The programs PAR reports and applicable attachments are placed in a central record within forty-eight hours of being signed by the FA. The program submits a monthly summary of all PAR reports to the Department by the fifteenth of each month. The program's PAR plan was approved and signed by the Department on May 23, 2018.

A review of PAR interventions since the last annual compliance review found the program had a slight increase. The FA indicated the program's increase is attributed to staff shortages. Staff resigned from the program to work for another program in the area. The program is working towards stabilizing culture and environment. Staff from other TrueCore Behavioral Solutions programs are being utilized to assist in providing coverage. In addition, new staff coming on-board will have on-site staff coaching from seasoned staff who will provide immediate direction, as needed. The FA indicated the chief of security or designee reviews a video of all PAR incidents. All PAR incidents are discussed during the morning management meetings. During all campus meetings the program discuss ways to avoid using physical interventions and emphasis on the use of verbal de-escalation techniques. PAR reports are sent to the Department by the fifth of every month. The program's PAR rate during the annual compliance review period was 0.76, which is below the statewide residential PAR rate of 1.47.

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

Seven staff training records were reviewed to verify pre-service training requirements. Four of the seven staff reviewed, were certified within 180 days of the staff's respective hire dates. One staff reached the 180 days of hire and did not complete the minimum of 120 hours of training with completing a total of 104 hours. Two staff had not reached their 180 date of hire and were still working towards completing some training The four staff who completed training within 180 days of their hire dates, each completed at least a minimum of 120 hours of pre-service training. A review all seven staff training records revealed the staff completed the following pre-service training including cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and Protective Action Response (PAR) training. Six out of seven staff completed

professionalism and ethics including standards of conduct, child abuse reporting and prison rape elimination act (PREA) training. One staff had not completed professionalism and ethics, child abuse reporting and PREA training and was not in contact with any youth. All seven staff completed suicide prevention and emergency procedures. All seven staff records also included evidence of completion for contract specific training in areas of gender specific services, post-traumatic stress disorder (PTSD), and universal precautions. Four of seven staff completed training in restorative justice practices. The program provided the following enhanced specialized training for the specific population in which staff provides intensive mental health treatment services. Each of the seven staff also completed training in grievance process, infection control, site-specific exposure control plan, intended and safe use of tools, and program specific behavior management system. Four training records indicated the completion of training requirements within the Department's Learning Management System (SkillPro). The instructors providing training are qualified to do so as a result of reviewing each instructor certification. The program submitted in writing a list of pre-service training to the Department's Office of Staff Development and Training which included the course names, descriptions, objectives, and training hours for instructor-led training. The pre-service training plan was submitted on December 18, 2017 and signed on December 28, 2017.

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

Seven staff training records were reviewed to verify in-service training requirements which included four direct care and three supervisory staff. Each of the reviewed seven staff received more than the required twenty-four hours of annual training. Each staff received training in cardiopulmonary resuscitation (CPR) (if required), first aid (if required), automated external defibrillator (AED) (if required), and refresher in Protective Action Response (PAR) training. Each of the seven staff received training in professionalism and ethics including standards of conduct. Six of the seven staff completed all the training for suicide prevention. One staff was missing four of the six required hours of the instructor-led training. Each of the three supervisory training records included at a minimum eight hours of additional training in management, leadership, personal accountability, employee relations, communication skills, and/or fiscal training. A review of six nursing staff training records found each have a current certification in CPR and AED training. Staff records reviewed for completion of in-service training found each was documented within the Department's Learning Management System (SkillPro). A review of the instructor certifications documented each are qualified to deliver the training provided. The program submitted in writing a list of in-service training to the Department's Office of Staff Development and Training which included the course names, descriptions, objectives, and training hours for instructor-led training. The in-service training plan was submitted on December 18, 2017 which was signed and approved on December 28, 2017. The program has an annual in-service training calendar which is updated as changes occur.

1.09 Grievance Process	Satisfactory Compliance

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

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

The program has a written facility operating procedure (FOP) which addresses the grievance process. The grievance written FOP also identifies training requirements for the grievance process. In addition, the FOP identifies each staff shall ensure youth requesting to complete a grievance be given the proper forms, assistance, and instructions on the preparation and submission of the form. A review of seven staff pre-service training records confirmed each staff completed the grievance process training. The program's grievance process includes an informal, formal, and appeal phase. Each of the phases included timeframes for review and completion within seventy-two hours. An interview with the facility administrator (FA) revealed the youth will initiate the grievance process by completing the informal phase either on the grievance form or utilizing the "Youth Speak Out" forms provided in the program areas. The youth advocate is responsible for checking the drop boxes for grievance and "Youth Speak Out" forms daily. They will document the date and time the grievance was received and attempt to resolve the issue through the formal phase. If a youth is not satisfied with the outcome, the youth can appeal the decision which will move the grievance forward to the appeal phase and handled by the facility administrator (FA) or the assistant facility administrator (AFA). The program maintains copies of all grievances for the past twelve months which were found in a three-ring notebook. The program had only one grievance within the last six months. A review of the grievances found each had the documented date of the initial completion for the grievance. The grievance documented it had been resolved during the formal phase and within the required time frame. The program's grievance process and process for completion of the "Youth Speak Out" forms are provided in the student handbook. A review of seven youth case management records found each youth signed an orientation checklist which documents the youth's review of the program's grievance process upon their admission. During a tour of the program, grievance forms were located and accessible to youth throughout the facility. Seven youth were interviewed and four were familiar with and able to summarize the grievance process. Three indicated they never had to complete a grievance form. Six of the seven interviewed youth reported they can ask staff for assistance when completing a grievance. Three staff were interviewed with regards to the programs grievance process for youth. Each staff was able to provide insight into the practices necessary for conducting the grievance process. The FA was interviewed and asked to explain the programs grievance process. The FA stated the first phase is speaking directly to staff, the second phase is to utilize the "Let's Talk form, and the third phase is the formal grievance form process. An appeal can always be made to the FA if the decision is found unfavorable.

1.10 Delinquency Interventions and Facilitator Training	Satisfactory Compliance

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

A review of the provider's contractual agreement revealed the required delinquency intervention services to be Thinking for a Change (T4C). The program's written description addresses the delinquency intervention strategies utilized and the curriculum is evidenced-based. The intervention and treatment team including the youth shall meet and develop the performance plan with achievable individualized delinquency intervention goals prior to the youth's release from the program. The performance plan should be based on the initial findings of the assessment of the youth and completed within thirty days of the youth's admission. The performance plan should facilitate the youth's successful reintegration into the community upon release from the program and to facilitate the youth's rehabilitation. The multidisciplinary intervention and treatment team should develop the performance plan and include goals specific to delinquency interventions with measurable outcomes for the youth to decrease criminogenic risk factors and promote strengths, skills, and supports the likelihood of the youth reoffending. A review of the program's activity schedule determined the program provides structured, planned programming, or activities at least sixty-percent of the youths awake hours. Seven youth records were reviewed and six were applicable for delinquency intervention services One youth had not been offered or participated in a delinquency intervention group, however, the youth will attend the next scheduled group. The remaining six youth were reviewed to ensure the program implements a delinquency intervention model or strategy with demonstrated effectiveness. The remaining three youth group sign-in sheets were reviewed and revealed each youth were receiving delinquency interventions, as prescribed. All reviewed six youth records supported each youth's performance plan addressed a identified priority need.

Four therapeutic staff who deliver delinquency intervention models were reviewed for training, education level, and years of working with adult or juvenile offenders. Each of the four reviewed staff received certifications for the respective delinquency interventions they deliver to the youth. All staff have the required education and years of experience. Education and work experience are considered by the facility administrator (FA) when determining staff delivery of delinquency intervention services at the program. An interview with the FA stated a review of staff education and background is conducted to ensure they meet all requirements. This process is a collaboration between the human resources department and the department head. Staff who hold special certifications are held accountable for recertifications needed to maintain their certification status. A pre-classification meeting takes place prior to receiving a new youth or once the youth arrives to the facility. A series of assessments are administered and a determination is made concerning the assignment of a case manager and therapist for the youth. The FA confirmed the delinquency intervention strategy utilized is T4C and case managers facilitate these groups.

1.11 Life Skills Training Provided to Youth	Satisfactory Compliance

The program shall provide interventions or instruction focusing on developing life and social skill competencies in youth.

The youth within the program receives life and social skill intervention services which addresses at a minimum communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking to include problem-solving and decision making skills. The program offers pursuant to contract Young Men's Work workbook, Life Skills 225, Living in Balance (LIB), Anxiety Workbook for Teens, Thinking for a Change (T4C), and Strategies for Anger Management. The youth's individualized needs are identified and prioritized through a comprehensive needs assessment process completed by a multidisciplinary intervention and treatment team staff. The youth's intervention and treatment team should identify the youth's criminogenic risk and protective factors, prioritize the youth's criminogenic needs, and determine the youth's risk to re-offend. Each youth shall be assigned to a multidisciplinary intervention and treatment team. The facility administrator (FA) designates the assigned case manager as the leader of the intervention and treatment team and is responsible to coordinate and oversee the team's efforts and facilitate effective management of each case assigned to the team. The program has a written facility operating procedure (FOP) which addresses how the services are provided. A review of the programs activity schedule demonstrates the youth are scheduled to receive life skills education, training, and or groups regularly. The programs life skill groups complete a sign-in sheet at every group encounter. A review of the group sign-in sheets was conducted to determine if life skills groups were being delivered as designed. Life skills programming and adherence by the program was discussed and verified with the person completing the review for standardized program evaluation protocol (SPEP). Youth were in attendance and participating in life skills groups at the program. A review of seven staff training records was conducted and each had documentation the staff were trained in the program's curriculum for specified life skills training. Seven youth records were reviewed for receipt of services outlined within each of their respective treatment plan and or performance plan Each of the youth received the applicable service delivery. Seven youth were interviewed and each were able to identify the groups and/or activities they participated in while at the program. All seven youth were able to identify the groups they participated in and what they learned while attending the groups. Youth were also able to describe some of the new skills and/or behaviors taught while in groups. Six of the seven youth were able to provide an example of how they practiced some of their skills while in and out of group. One youth commented they fill out worksheets.

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.	

Seven youth case management records were reviewed for delivery of restorative justice awareness. Each of the seven youth received services to increase accountability for criminal actions and harm to others. The program provides on-going community activities designed to assist youth to accept responsibility for harm they have caused by their past criminal actions. In addition, the activities challenges youth to recognize and modify their irresponsible thinking such as denying, minimizing, rationalizing, and victim blaming. Some of the restorative activities were clean-up projects, partnership with Habitat for Humanity to build and paint homes, engaging in discussion concerning restorative justice, and how youth can give back to the community with local law enforcement (), car wash to raise money to benefit a local charity, and trash pick-up in

the community. These practices teach youth about the impact of crime on victims, their families, and communities. Discussions held with community members exposes the youth to the victim's perspectives which allows the youth to process reactions to each victim's account of how the crime impacted their life. Having the youth involved in these type of community activities serves as restitution intended to restore victims and communities. The program has a youth advocate who maintains a binder which is specific to restorative justice awareness activities. The youth advocate creates a calendar for community service activities, takes pictures of the youth participating in activities, and includes documentation of the restorative activities in the binder, monthly. Documentation of these activities include the type of community project, youth involvement, and photos of projects/activities youth are participating in. An interview with the facility administrator (FA) e described the types of restorative justice awareness groups or activities provided for the youth. The facility recreational therapist and transition service managers utilize on campus groups and activities, and a variety of community service programs to expose youth to restorative justice practices. Youth at Gulf Academy participated in community clean up events, a Lupus rally, and created an internal cancer awareness picture collage in support of a staff whose family member was affected by the disease.

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

A review of the provider's contractual agreement found Male Healthy Relationships and Young Men's Work curriculum is the required service for gender-specific programming. The program designs the services based on the common characteristics of the male population. A review of the program's activity schedule found evidence of provisions for gender-specific programming. The curriculum used to instruct youth on gender-specific issues was reviewed, as well as sign-in sheets to determine consistency with group facilitation. An interview with the facility administrator (FA) revealed the program provides targeted health education, male medical exams, group curriculum, daily groups with specialized topics, and a Male Health Relationship bundle such as Young Men's Work and Teen Relationships, and recent discussions of lesbian, gay, bisexual, transgender and intersex (LGBTI) youth specific groups for youth who self-identify in this category.

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

The program has a written facility operating procedure (FOP) concerning the internal alert system. The FOP provides direction on how alerts are identified, documented, updated, and communicated to employees. The program utilizes the Department's Juvenile Justice Information System (JJIS) for entering and removing alerts on identified youth. A review of alerts

contained within JJIS and the programs internal alerts were consistent with one another. There were no issues found from each team member for mental health, medical, case management, and safety and security. There was evidence all youth were placed within the programs internal alert system, as specified within the programs written FOP. A review of the programs logbook documentation found the youth were removed or downgraded from alert status by the appropriate staff. There were no noted inconsistencies. The facility administrator (FA) was interviewed concerning the program's alert system and reported alerts are reviewed and discussed during the morning meetings. The mental health, medical, operational, and clinical staff have access to enter and close out alerts in JJIS. The program also maintains an alert board and all department heads receive internal alert sheets. Three interviewed staff reported they are notified of alerts through shift briefings, alert board, shift supervisor, at the beginning of each shift, and master control. A review of seven internal alerts was completed and all seven were clearly identified on the date the alert was entered into JJIS. For those applicable alerts which were recommended to be downgraded or otherwise discontinued, each was completed by appropriate staff required to do so. Documentation was found within the programs logbook identifying the alert status, as needed.

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

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

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

The program makes efforts to solicit input from youth. The youth advisory board and community meetings are conducted monthly. Topics for these meetings included items such as program and youth concerns, youth leadership, new ideas and activities, menu planning, youth outings, and open floor discussion. Documentation of sign-in sheets and meeting minutes were observed to confirm consistency with conducting both the youth advisory board and community meetings. In addition, the regional director (RD) reported youth surveys are completed quarterly for all youth. Parent surveys are also completed upon a youth's admission to the program. The surveys are completed electronically and results are forwarded to the corporate office. Data collected from the surveys is compiled and shared with facility administrators and all staff members during staff meetings. Youth also have access to the surveys and "Let's Talk" forms which are located in all program areas. A secured drop box is provided for youth to return the completed forms. The boxes are checked daily by the youth advocate. The youth may use the forms to speak directly with a staff member or a member of administration concerning an issue the youth may have. The facility administrator (FA) was interviewed concerning youth input at

the program. The FA reported the program utilize dorm meetings, youth advisory boards, treatment teams, and community advisory board to solicit input from the youth concerning the program. Seven youth were interviewed and five reported they were aware of ways to provide input such as dorm meetings, “Let’s Talk” forms, talking to staff directly, and surveys. One youth did not have an idea on how to provide input and another youth responded no, but reported having dorm meetings, sometimes.

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

The program has a community advisory board which is required to meet at least quarterly. The program maintains meeting sign-in sheets, minutes, and agenda topics in a community advisory binder. The meetings are facilitated by the program’s youth advocate. There was evidence the program solicits information from law enforcement, victim advocates, and the parent/guardian of a youth previously involved in the juvenile justice system, judiciary staff, community partners, business community, school board, and the faith community. A review of the meetings minutes found the program completed meetings for two of the previous three quarters. The regional director (RD) reported a meeting was scheduled for the first quarter but was rescheduled due to a conflict. Telephone contact was made with a community member to confirm their participation in the meetings. The community member was a representative of the faith community and confirmed they have enjoyed participating with the program and looking forward to working with the program to improve opportunities for the youth. The facility administrator (FA) was interviewed and stated the community advisory board meets quarterly and during the meetings updates of program information are provided. Feedback is solicited and youth are invited to attend to provide feedback or to express needs or concerns. The FA reported an example of implementing improvements from the board by furnishing a clothing closet for youth in the program who are released without clothing or those youth in need of clothes for job interviews. Board members have also been instrumental in providing resources and materials which are needed for the youth during placement such as books, vocational services, and activities.

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

The program has a written facility operating procedure (FOP) which allows for inclusion of information from a variety of sources to ensure staff are informed of programmatic issues. An interview with the program’s regional director (RD) and facility administrator (FA) revealed the program facilitates the following meetings to discuss program planning information such as morning management meetings and all campus meetings. Morning management meetings are conducted daily and include representatives from each department head to discuss the status of their areas. Minutes are documented on a web-based system which develops trend data and is further reviewed at the corporate level. Sign-in sheets and minutes were observed of these meetings to confirm consistency. In addition, the program provides surveys for the parents/guardians and youth. The information obtained in these surveys are discussed at the management meetings. Documentation of these surveys were reviewed to ensure consistency with the practice. All campus meetings are facilitated by the program administration each month. Discussions for these meetings include incident report information, protective action response (PAR) reports, employee recognition, and various youth issues. The meetings are attended by all direct and non-direct care staff members. An interview with the FA revealed these meetings

may also be utilized for staff training days. Announcements for these meetings are posted within program areas. Agendas, minutes, and employee sign-in sheets for these meetings were also observed to show consistency with the practice. An interview with the FA revealed the program has an employee retention committee which meets on Thursdays. The meetings are facilitated by the FA. The employee retention committee was initiated during the previous two months of the annual compliance review. Agenda topics discussed are retention and activity planning for staff. Observations of meeting minutes and sign-in sheets were confirmed the practice. The FA was interviewed concerning staff turnover and retention efforts. The FA reported the program was down several youth care workers and key administrative staff positions when hired as the FA in October 2018. Recruitment in the program has been an ongoing struggle; however, recruitment in the program has been an ongoing struggle and staff has done their best to bring in a class every month over the past three months. To address morale, the FA reported the team and the FA reintroduced employee recognition events through employee of the month awards, drawings for gifts, and the recognition of staff birthdays. In addition, program administration works with human resources and the training department to identify creative ways to recruit and onboard new staff. The FA reported they have recently held open interviews for all staff vacancies. The FA was interviewed to explain the outcome data used by the program. The FA reported annual youth and staff surveys, Central Communication Center (CCC) reports, PAR Reports, and educational assessments are all used to track the program's outcome data. The information from these reports are shared on a regular basis with staff and utilized to set department goals. The commission accreditation report (CAR) is posted on the bulletin board in the administration area and is accessible for all staff to review. Three staff were interviewed concerning program planning and all three reported staff meetings were held monthly. The staff reported meeting topics included searches, contraband, ratio, staff call outs, time sheets, anniversary for staff, and ideas to make the program better. Additional topics includes policy and procedures, team moral, consistencies, years of service, team work communication, and training topics. All three staff reported they were briefed on CAR reports, annual compliance reports, or youth and parent/guardian surveys. One staff reported the communication at the program was very poor. One staff reported it was good and one staff reported it was very good.

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

The program has a written facility operating procedure (FOP) for evaluating staff and their performance standards as well as outlining the frequency of staff evaluations. The policy indicated evaluations for staff are done annually. A review of four sample job descriptions included the youth care worker, therapist, shift manager, and a unit manager positions. Each job contained a position description which clearly identified the performance standards. The performance standards matched the job descriptions for each staff's position. A review of four staff personnel records found each had a completed annual evaluation in their record. The evaluations were completed as outlined within the programs written FOP. The program reported having the following vacant positions which were identified as key positions within the provider's contractual agreement as one assistant facility administrator (AFA), certified behavioral analyst, and an assistant clinical director. The FA was interviewed and stated staff receives an annual performance evaluation which gives a score on a scale of zero to three. In addition, the supervisor has the opportunity to set three goals for their direct reports. Three staff were interviewed of which two staff reported they receive an evaluation, annually and two staff reported they receive an evaluation once every six months.

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.	

A review of seven records was conducted and in all cases the parent or guardian was notified by telephone within twenty-four hours of the youth's admission to the facility and in writing within forty-eight hours of admission. In all records the court, the juvenile probation officer (JPO), and post residential services counselor were notified of the youth's admission within five working days.

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.	

A review of seven youth records and an interview with seven youth confirmed all were provided an orientation within twenty-four hours of their admission to the program. The orientation process includes all the instances of services available such as a daily schedule posted around the facility to allow easy access for youth, youth expectations and responsibilities, a written behavioral management system which is also posted around the facility outlining the rules governing conduct to include the positive and negative consequences for behavior, availability of and access to medical and mental health services, and access to the Florida Abuse Hotline. Youth are informed of items considered as contraband and such items which can result in further prosecution. Youth are also informed of the program's performance planning including the development of goals for each youth to achieve, dress code and hygiene, visitation, mail, and telephone procedures. Youth are given an anticipated length of stay at the program with expectations for their release which includes successful completion of individual performance plan goals, program's recommendation to the court for release based on individual performance, and the court's decision to release the youth. The program's orientation informs the youth of community access, grievance procedures, emergency procedures which include fire drills and building evacuation, physical design of the facility, areas accessible and not accessible to youth, assignment to a living unit and room, treatment team and staff advisor or youth group. The facility documents new admissions in the facility logbook.

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

Three records were reviewed for written consent of youth eighteen years of age or older prior to providing or discussing information related to physical or mental health screening, assessment, or treatment with the parent/guardian. In all records a signed consent was obtained and maintained within each record.

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

According to the facility administrator (FA) classification factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are examined and taken into consideration during the pre-classification process which also helps with setting goals for the youth. The program's written policies and procedures clearly outline the classification and reclassification process. A review of seven youth case management records indicated the program has a classification system in place which includes each youth physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization. Other identified or suspected risk factors considered includes suicide risk, medical risk, escape risk, security risk, and a review of all Juvenile Justice Information System (JJIS) alerts which affect classification. All youth are classified for the purpose of assignment to a living area, sleeping room, and youth group or staff advisor. In two records medical, mental health, substance abuse, security risk factors, and/or special needs were identified during or following the classification process and immediately entered into the program's internal alert system and in JJIS. Reassessments were needed in five cases prior to considering an increase in youth privileges or freedom of movement, participation in work projects or other activities involving tools or instruments which may be used as potential weapons or means of escape, and participation in off-campus activities.

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.	

Three applicable youth case management records were reviewed and each indicated the youth had some type of gang involvement. In each case the local law enforcement was notified of suspected gang activity by the program, detention staff, or the youth's juvenile probation officer (JPO). None of the youth were currently placed in a residential commitment placement in their home county. Law enforcement in their home county was also notified. Information pertaining to the youth's gang status was also shared with the educational provider and the JPO. Notification to the youth's post-residential counselor was not applicable in the records reviewed.

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.	

Three applicable youth case management records reviewed for gang involvement were identified as gang members. All youth participated in gang prevention and intervention strategies with relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release which was included in their performance plan. Gulf Academy incorporates a curriculum which includes Gang Resistance and Drug Education Curriculum (GRADE) which is comprised of seven lessons on setting goals, respects, making good choices, conflict resolution, internet safety, gang intervention, and drug awareness. Other prevention and intervention strategies implemented include information about Gangs in America, What is a Gang, Facts About Gangs, A History of Gangs, and Crimes Committed By Gangs.

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

A review of seven youth case management records found all were administered a Residential Positive Achievement Change Tool (R-PACT) within thirty days of the youth's admission to the program. The R-PACT was maintained in the Juvenile Justice Information System (JJIS). In all cases, a re-assessment was completed with three re-assessments completed within ninety days of the initial assessment date. Of the four re-assessments completed late, they were completed six, seven, eighteen and, fifty-seven days after the required due date. Any other updates and/or re-assessments were not applicable in all records.

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

Seven youth case management records were reviewed and six had a completed Youth Needs Assessment Summary (YNAS) within thirty days of the youth's admission to the program and documented in Juvenile Justice Information System (JJIS). The seventh YNAS was completed one hundred and twenty-three days late.

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.*	

A review of seven youth records found six indicated an Individualized Performance Plan (IPP) was developed within thirty days of the youth's admission into the facility. One IPP was two days late. The IPP was completed after the initial Positive Achievement Change Goal (PACT) assessment in all seven youth records. The treatment team included the treatment leader, the youth, an administrative representative, a living unit representative, treatment staff, and education staff were present during the IPP development. In two cases a Department of Children and Families (DCF) Caseworker was also present; the remaining five were not applicable for DCF involvement. In all cases the IPP was signed by the youth, the intervention and treatment team leader, and all other parties with significant responsibility in the goal completion. In three of the seven records reviewed the residential case manager maintained the parent/guardian signature sheet which was attached to the original performance plan in the youth's official case management record. The remaining four signature sheets were not returned to the program. In all records, the performance plan included individualized goals which were based on the prioritized needs reflecting the youth's risk and protective factors which were identified during the initial assessment process. The plan addressed the top three criminogenic needs and if not, a reason was documented as to why within the record. Each of the seven performance plans addressed specific delinquency interventions with measurable outcomes which will decrease criminogenic risk factors and promote strengths, skills, and supports which reduce the likelihood of the youth reoffending. All plans targeted court ordered sanctions which can be reasonably initiated and/or completed while the youth is in the program, transition activities targeted for the last sixty-days of the youth's anticipated stay and includes youth and program staff responsibilities for accomplishing goals, and the anticipated target date for completion. Within ten working days of the completion of the plan, the program forwarded a transmittal letter and a copy of the plan to the committing court, the juvenile probation officer (JPO), and the parent/guardian. In two of the cases the plan was sent to the DCF caseworker. An interview with seven youth indicated all participated in the development of their performance plan, understood their current performance plan goals, and were provided a copy of their performance plan.

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

Seven youth case management records were reviewed and four included revisions to the individualized performance plan due to the Residential Positive Achievement Change Tool (R-

PACT) re-assessment results and/or the youth's demonstrated lack of progress toward completing a goal. Revisions to the IPP were based on newly acquired information and the youth's demonstrated progress. The need to facilitate transition activities during the last sixty days of the youth's stay were not applicable.

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.*	

Seven youth case management records were reviewed and six were completed ninety days following the signing of the initial performance plan which one was not applicable. Four of the seven records included summaries which was prepared prior to the youth's release, discharge, or transfer from the program, three were not applicable. The ninety day summary included the youth's status on each performance goal, the youth's overall treatment progress, academic status, credits earned in the program if a high school student, school performance, school behavior, the youth's behavior, the youth's level of readiness and/or motivation to change, interactions with peers, interactions with staff, overall behavior adjustment to the program, and significant positive and negative events in six applicable records. Justification for release was not applicable in any of the seven records at the time of the ninety-day summary completion. In the six applicable records, the youth were allowed to read and add comments before signing the performance summary. The youth was provided a copy of the summary. The original summary was recorded in the youth's case management record and was signed and dated by the treatment team leader, staff member preparing the summary, program director (PD) or designee, and the youth. In six of the applicable records, a copy of the summary was forward to the committing court within ten working days. Five of six summaries was forward to the juvenile probation officer (JPO), six to the youth, two of four to the parent/guardian, and one of two to the Department of Children and Families (DCF). In four applicable records, an original summary with justification for release was forward with a Pre-Release Notification (PRN) to the JPO at least forty-five days prior to the youth's anticipated release date. In two applicable records, a signed copy of the approved PRN was maintained in the youth's case management record. The remaining two youth's PRNs had been received by the program. In three applicable cases, the program provided written notification to the youth's parent/guardian of the approved PRN and completed an exit Residential Positive Achievement Change Tool (R-PACT) in two of the applicable cases. None of the youth were applicable for the Sexually Violent Predator Program (SVPP) nor the youth have offenses which required victim notification.

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

The program encourages and facilitates involvement of the youth's parent/guardian in the case management process which includes the assessment process, participation in the development

of the youth's performance plan, progress reviews, formal treatment team meetings, and transition planning. If the parent/guardian is unable to attend the meeting, they are given the opportunity to participate by telephone, video conference, or able to provide verbal and/or written input prior to the meeting. A review of the facility's contract determined the outlined performance expectations are being met. The parent/guardian is called during pre-classification and given an overview of the program and introduced to their child's therapist and case manager. The parent/guardian will receive a formal letter in the mail recapping the information shared during pre-classification. Parents/guardians are encouraged to participate in treatment teams, weekly phone calls, write and send letters, family days, and family therapy. Seven youth were interviewed and six acknowledged their parents/guardians participate in case management services.

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

Treatment team members include the treatment team leader, the youth, administrative representative, living unit representative, treatment staff, educational staff, Department of Children and Families (DCF), juvenile probation officer (JPO), parent/guardian, and the program's gang prevention specialist. All members participate in treatment team; however, if they are unable to attend in person they are allowed the opportunity to participate by telephone and/or provide written input prior to the 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.	

A review of seven youth case management records indicated all youth had an academic plan which was referenced and incorporated into the performance plan. Five had a separate treatment plan relating to medical, mental health, substance abuse, and developmental disability which was referenced and incorporated into the performance plan. Two were not applicable. None were applicable for a current behavior support plan or case plan through the Department of Children and Families (DCF) and/or Agency for Persons with Disabilities (APD).

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

A review of seven youth case management records indicated the juvenile probation officer (JPO), the parent/guardian, and all other pertinent parties were invited and encouraged through

advance notification to participate in formal treatment team meetings. If the parties were unable to attend, the opportunity to provide written or verbal input was provided. Formal treatment teams were held at least every thirty days. Biweekly informal reviews were held at least once each month. Formal and informal performance reviews were documented in the youth's record and included the youth's name, date of the review, comments from treatment team members or others, brief synopsis of the youth's progress, progress on the performance plan, positive and negative behaviors, an opportunity for the youth to demonstrate acquired skills, and treatment progress. Formal treatment teams also documented the meeting attendees to include the youth, representative from program administration and living unit, and others directly responsible for providing or overseeing provision of intervention and treatment services to the youth. During formal and informal treatment team, four records were applicable for performance plan revisions and were included in the documentation. Six were applicable for a Residential Positive Achievement Change Tool (R-PACT) re-assessment and three were documented in the youth's record. There were no behaviors which resulted in any type of physical intervention. Seven youth were interviewed and six indicated they were provided the opportunity during treatment team meetings to demonstrate skills they learned while at the program. All youth indicated staff review youth performance to include progress on performance plan goals, positive and negative behavior, and treatment progress.

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

Interviews with the program director (PD) and the lead teacher indicated career education services and assessments offered to the youth in the program includes food management, food handling, Home Builder Institute (HBI), Positive Achievement Change Tool (PACT), career source résumé writing, Florida Ready to Work certification, cardiopulmonary resuscitation (CPR) and first aid. Upon admission, youth are provided with a O-Net assessment for career profiling. Three closed youth case management records were reviewed and each had a completed sample employment application, a résumé summarizing educational and work experience career training, a calendar or schedule identifying an appointment with Career Source Center, appropriate documents with essential information to obtaining employment, and documentation the youth's parent/guardian and juvenile probation officer (JPO) are aware of the youth's vocational plan by their completion of the program. The program provides appropriate career education based on age, length of stay, and is appropriate for the educational abilities of the youth in the 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's teachers provide education on a 250 days calendar which consists of six fifty-minute classes from the hours of 7:15 a.m. to 2:15 p.m. The youth receive credits for the education and training received while at the program. The program's activity schedule and logbook documented minimal interference of educational instruction and the classes are taking place as scheduled. Seven youth were interviewed and two indicated there are some interruptions during educational instruction to include disrespectful behavior on the youth's part.

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

Seven youth case management records were reviewed for educational transition plan. Each record had an individual education transition plan developed based on the youth's post release goals, beginning at admission to include all key personnel related to transition activities which included responsibility requirements and post release needs. Three closed youth records were reviewed for employability as a transition goal and included provisions for continuation of education and/or employment, appropriate documents essential to obtaining employment, and documentation the youth's case manager and parent/guardian are aware of the plan.

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

A review of four applicable youth case management records found two had a transition conference held at least sixty days prior to the youth's targeted release date. The transition conference were held fifty-five and fifty-seven days late. The program corrected the issues as soon as they were aware. The our applicable youth records documented the youth, the treatment team leader, and any other pertinent members were in attendance. In three of the youth case management records, the program director (PD) or designee was in attendance. Prior to the transition conference the youth's juvenile probation officer (JPO), parent/guardian, education staff, and any other pertinent parties were invited and encouraged to attend. During the conference transition activities the target completion dates and persons responsible for completion of activities were identified and reviewed. The treatment team leader obtained all attendees' signatures with dates which represented their acknowledgement of the transition goals and accountability for completion. There were no revisions and identification of additional transition activities of the records reviewed. One record required a copy of the plan sent with a request for return with signature, which was completed. Three records included a copy of the youth's plan which was transmitted electronically to the JPO and/or the Department of Children and Families (DCF) in which a copy of the email acknowledgement was printed and recorded with the transition plan in the youth's record. Two applicable records were reviewed for completion of a community re-entry ream (CRT) meeting. The CRT was conducted prior to the youth's release in which the youth and the case manager both participated. Evidence of an invitation was received for participation in the CRT which was maintained within the youth case management records.

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

Three closed youth case management records were reviewed for completion of an exit portfolio. In all three cases the exit portfolio was discussed and initiated at the time of the transition conference. Documentation in all three youth records confirmed the exit portfolio included a state issued identification card, a copy of the youth's transition plan, calendar of appointments with all dates, times, and locations of follow up appointments in the community, birth certificate, vocational certificate(s) earned while in the program, educational records and transcripts, a résumé, and a completed sample job application. Two records included a copy of the youth's social security card. Education staff in all cases forwarded the exit portfolio information to the receiving school district. The exit portfolio was verified at the exit conference and was given to the youth at release. The portfolio was forwarded to the juvenile probation officer (JPO) as documented in the youth's case management record. There were no youth records reviewed which were secure maximum risk.

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

Three closed youth records were reviewed for the completion of an exit conference and each had an exit conference conducted after the program notified the juvenile probation officer (JPO) of the youth's release. In two of the three cases the exit conference was conducted at least fourteen days prior to the youth's release and the third case was late by two days The conference was documented in the youth's case record to include the date, signatures, and summary of the pending transition goals. During the exit conference the status of the youths' transition activities were reviewed. All required staff and the parent/guardian participated in the exit conference. The Juvenile Justice Information System (JJIS) was updated accordingly and correlated with the youth's admission and release date in the record.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed psychologist who serves as the designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the State of Florida, expiring on May 31, 2020. The DMHCA is also a qualified mental health counselor supervisor and serves as the program's clinical director. The DMHCA is on-site forty hours each week and is on call, as needed. An interview with the DMHCA indicated their role includes the delivery of therapeutic and evaluation services for youth, and consultation with the facility psychiatrists at least twice a week to coordinate services and address diagnostic and medication needs. The DMHCA works with the assistant clinical director to provide weekly clinical supervision of the non-licensed mental health counselors to include a review of youth presenting with problematic treatment issues, discussion of documentation quality, and other relevant topics. The DMHCA provides oversight of evaluations of youth identified as being in need of suicide and crisis assessments. The DMHCA provides training for new therapists and the implementation of additional standards for evaluation and treatment.

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

The program has two licensed psychiatrists who are medical doctors board certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology. Both psychiatrists have a clear and active license in the State of Florida, expiring on January 31, 2020. Each psychiatrist is on-site sixteen hours each week. The contract agreements were signed by the psychiatrist and the program's chief executive officer (CEO) in 2018. The contract renews year to year. The program has a licensed mental health counselor (LMHC) who serves as the assistant clinical director for Hastings Juvenile Residential Facility. The LMHC has a clear and active license in the State of Florida, expiring on March 31, 2019. The LMHC is on-site forty hours each week and is also a qualified mental health counselor supervisor.

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

The program has four non-licensed mental health and substance abuse clinical staff. One non-licensed staff is a registered mental health counselor intern. Each staff member has a master's-level degree in counseling, social work or related human services field. All four clinical staff are on-site forty hours each week and each works one weekend every three weeks, as a rotating weekend and holiday schedule. The program is licensed in accordance with Chapter 397, Florida Statutes to provide substance abuse services for outpatient treatment. The license was signed on March 9, 2018 with an effective date of April 8, 2018, expiring on April 7, 2019. Six months of clinical supervision logs were reviewed for the four non-licensed mental health and substance abuse clinical staff. Three of the four clinical staff received at least one hour each week of clinical supervision by a licensed mental health clinical staff. One clinical staff was missing one week of clinical supervision from a licensed mental health clinical staff member. Each clinical supervision log contained five sections to include a caseload review, clinical services, documentation, miscellaneous, and standardized program evaluation protocol (SPEP) review. The program provided documentation of each non-licensed mental health clinical staff completed the required twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services in order to conduct Assessments of Suicide Risk (ASR). A review of seven youth mental health treatment records found the licensed mental health staff is providing direct supervision of the non-licensed staff. The licensed mental health clinical staff reviews and signs the comprehensive mental health and substance abuse evaluations, ASRs, and initial and individualized mental health and substance abuse treatment plans. The program had one crisis assessment which was completed by a licensed mental health clinical staff.

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

The program has a policy and procedures addressing the standardized screening process for all new admissions. The policy details the procedures for reviewing the youth's electronic commitment packet (ECP) and the completion of a records review. The procedures outline the intake requirements which includes the completion of a Massachusetts Youth Screening Instrument (MAYSI-2) at the time of the youth's admission, completion of an Assessment of Suicide Risk (ASR) on the date of admission, and the completion of a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) tool within 24 hours of the youth's admission. The ASR is to be done after the completion of the MAYSI-2, VSAB, and the records review. The policy explains if an ASR identifies a case as urgent and if determined an emergency exists, staff are to follow the facility operating procedures for emergency care. The emergency care includes the procedures for transportation for emergency mental health and treatment for a Baker Act and transportation for emergency substance abuse assessment and treatment under the Marchman Act. The program also maintains a policy and procedures addressing assessment services. The policy indicates all youth are to obtain a comprehensive

mental health and substance abuse assessment within thirty days of admission regardless of the results of the initial screenings completed during the intake process. Seven youth mental health records were reviewed for mental health and substance abuse admission screening. Six records documented a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) was completed in the Department's Juvenile Justice Information System (JJIS) on the date of the youth's admission. The remaining record contained the paper copy of the MAYSI-2 completed by the youth on the date of admission; however, the responses were not entered into JJIS until 117 days after the youth's admission. An interview with the assistant clinical director indicated this oversight was identified during a mock audit and the MAYSI information was entered into JJIS when it was found. Each assessment was completed in JJIS by a clinical staff member who is trained to complete the MAYSI-2. The results of the MAYSI-2 indicated five of the seven youth were in need of further assessment in areas to include alcohol/drug use, depressed/anxious, somatic complaints, suicide, thought disturbance, and traumatic experiences. Each record contained a completed VSAB on the date of the youth's admission, as well as a records review form which documented a review of the commitment packet, the youth's comprehensive evaluation obtained prior to placement, the face sheet, alerts, and the Community Positive Achievement Change Tool (C-PACT). Additional screenings completed included a University Rhode Island Change Assessment Scale (URICA) and an assessment tool to determine if there is a need for substance abuse treatment. An interview with the facility administrator (FA) reflected the program utilizes the MAYSI-2 during the admission screening process to identify youth at risk of mental health, substance abuse, or suicide.

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.	

Seven youth mental health records were reviewed for mental health and substance abuse evaluations. The program's policy indicates all youth are to receive a comprehensive evaluation within thirty days of admission. Six records contained a new comprehensive mental health and substance abuse bio-psychosocial evaluation. One record contained an updated evaluation with the original comprehensive evaluation maintained in the mental health record. Each comprehensive evaluation was completed by a non-licensed mental health clinical staff member within thirty calendar days of the youth's admission which was reviewed and signed by a licensed mental health professional (LMHP) within ten calendar days of the completion of the evaluation. Each evaluation contained the youth's demographics, reason for the evaluation, relevant background information, behavioral observations, mental status examination, and the interview or procedures administered. Each comprehensive evaluation addressed patterns of alcohol or other drug abuse, the impact of alcohol and other drugs on major life areas, and the risk factors of continued alcohol and other drug abuse. Each evaluation included a summary of clinical impressions, a diagnostic impression, and recommendations for treatment. Each record contained consents for substance abuse services signed by the youth, a clinical staff member, and a witness.

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.*	

Seven youth mental health records were reviewed for mental health and substance abuse treatment. Each of the seven reviewed records documented the youth was assigned to a treatment team upon their admission. Documentation confirmed the participants included the youth, program administration, the residential living unit, clinical staff, and education staff. Documentation reflected the medical department provided updates for treatment team utilizing a medical compliance report. Six of the reviewed records contained a properly executed Authority for Evaluation and Treatment (AET). The remaining record contained an AET signed by a previous parent/guardian; however, after a change of the parent/guardian an updated AET was yet to obtained by the program. The medical department had three documented attempts to obtain an updated AET from the parent/guardian. Each record contained documentation of a youth's consent for substance abuse treatment and a release of substance abuse records. The records and group sign-in sheets confirmed mental health groups did not exceed ten youth and substance abuse groups did not exceed fifteen youth. Six of seven records documented the youth received mental health treatment to include individual, family, and group counseling in accordance with their individualized mental health and substance abuse treatment plan. The remaining record documented the youth received services in accordance with the individualized treatment plan with one exception of a missed family session; however, the record did document the program made three attempts to contact the parent/guardian in order to conduct the family counseling session. The mental health and substance abuse treatment notes were documented on a program form with all the required elements of the Department's Mental Health and Substance Abuse (MHSA) form 018. Treatment was provided by a licensed mental health professional(LMHP) or a non-licensed mental health professional under the direct supervision of a licensed mental health clinical staff. Six of seven youth interviewed reported they are participating in groups. The remaining youth reported they completed their groups as they are near their release date. Five youth reported they are participating in anger management and substance abuse prevention groups. One youth reported they are participating in a substance abuse group. Three staff members were interviewed and each reported they do not facilitate mental health or substance abuse groups.

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

Seven youth mental health records were reviewed and each record contained an initial treatment team completed on the date of the youth's admission. Each initial mental health treatment plan contained the required elements of the Department's Mental Health and Substance Abuse (MHSA) form 015 to include a reason for mental health treatment, an initial diagnostic impression, initial treatment methods, and the initial treatment goal and objectives. The plan was signed by the youth, mental health representative, case management representative, living unit representative, licensed mental health counselor (LMHC), and program administration. Each plan included the youth's psychiatric needs. Each record contained an individualized treatment plan which was documented on a form containing all of the required elements similar to the Department's MHSA form 016 which was developed within thirty days of the youth's admission. The individualized plan was signed by the therapist completing the form and the licensed mental health therapist within ten days. The plans were signed by all treatment team members and included psychiatric services, psychotropic medication management, and the frequency of monitoring youth receiving psychotropic medications, when applicable. Each record documented monthly treatment team reviews. Three closed youth records and an additional open youth record containing a discharge plan was reviewed. Each plan included recommendations for services for daily maintenance upon discharge. None of the youth were applicable for being discharged on a suicide alert and/or suicide precautions. Documentation reflected the discharge plans were discussed with the youth, the parent/guardian, and the juvenile probation officer (JPO) during the youth's exit conference. Two of the discharge plans were signed by the parent/guardian. The program's acceptance of custody release form documented the youth, and the parent/guardian received a copy of the MHSA discharge summary upon release in the three closed records. A copy is also sent to the JPO.

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

The program provides intensive mental health services, intensive medical overlay services, and borderline developmental disability services. At the time of the annual compliance review, the program had thirty-six youth receiving intensive mental health services. The program provides group therapy daily to include five days a week of mental health groups and two days of substance abuse prevention groups. The program clinical staff provides supportive counseling sessions, as needed. Individual and family counseling is provided to the youth as well. The program has on-site psychiatric services with a psychiatrist on-site at least two days each week.

The clinical director and assistant clinical director are licensed mental health professionals (LMHP) and each are on-site forty hours each week. The non-licensed therapists are on-site five days each week, with a rotating weekend schedule for on-site coverage seven days a week. The program has a registered nurse (RN) on-site twenty-four hours a day, seven days a week.

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

The program has two licensed psychiatrists who are medical doctors board certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology. Both psychiatrists have a clear and active license in the State of Florida expiring on January 31, 2020. A copy of the licenses was available for review and the contract agreements were signed by the psychiatrist and the chief executive officer (CEO) in 2018. Each contract renews year to year. Each psychiatrist is on-site sixteen hours each week and is available by telephone twenty-four hours a day, seven days a week for emergency consultation. The program has a policy and procedures addressing psychotropic medication management, which was reviewed annually in July 2018 and February 2019. The policy details the procedures for health care staff, the program psychiatrists and clinical staff to follow regarding psychotropic medications, medication management, side effect monitoring, consent and notifications requirements for youth receiving psychotropic medications, a youth's refusal of psychotropic medications, and court ordered psychotropic medications. A review of seven youth mental health records reflected five youth entered the program on psychotropic medications. Each of the five youth received an initial diagnostic interview with the psychiatrist within fourteen days of admission. The remaining two youth did not enter the program on psychotropic medications received an initial psychiatric interview within fourteen days of being referred. Each form was titled as the initial diagnostic psychiatric interview which included an explanation of the presenting problem, history of present illness, clinical symptoms, medication management, a mental status exam, and diagnosis. The evaluation included the youth's past psychiatric history, current medications, medical/physical history, and treatment recommendations. The evaluation explained the need for psychotropic medications related to the youth's diagnosis, target symptoms, potential side effects, and the risk and benefits of taking the medication in the five applicable youth records and one in the one the remaining youth's record who was being recommended for psychotropic medications. Each youth received a psychiatric evaluation within thirty days of their admission. One youth was discontinued from psychotropic medications and the five youth who are receiving psychotropic medications received a medication management review at a minimum of every thirty days by the licensed psychiatrist. Each record documented psychotropic medications or changes to the youth's existing medications were documented on page three of the Clinical Psychotropic Progress Note (CPPN). Two of the CPPNs documented the parent/guardian did not agree with the treatment plan. One of the remaining two youth did not have a change in medication and the other youth had an increase in medication. A previous CPPN reflected the parent/guardian consented to the dosage range being prescribed to the youth. The program reported this matter was addressed with the psychiatrist and this box is marked when the psychiatrist is notable to get in touch with the parent/guardian. There were no standing orders for psychotropic medications or emergency treatment orders for psychotropic medications. One youth was involved with the Department of Children and Families (DCF) and the program was waiting on consent to initiate a new psychotropic medication.

Sign-in logs and treatment team meetings verification notes were reviewed which confirmed the psychiatrists briefed a treatment team representative on the psychiatric status of each youth receiving psychiatric services. The psychiatrists are on-site, as required by the contract. An interview with one of the program's psychiatrists confirmed they are on call twenty-four hours a day, 365 days a year. Coverage is provided in the event a psychiatrist is on leave. The program does not utilize an advanced registered nurse practitioner (ARNP). The psychiatrists are responsible for evaluating new youth admitted to the program, as well as the prescription and monitoring of psychotropic medications as clinically indicated.

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

The program has a policy and procedures to include a written suicide prevention plan which was reviewed by the designated mental health clinician authority (DMHCA) on July 3, 2018 and signed by the facility administrator (FA) on February 13, 2019. According to policy, an Assessment of Suicide Risk (ASR) is to be completed for each youth during the intake process. The procedures outlined the identification and assessment process, suicide precautions, the levels of supervision to include one-to-one supervision, constant supervision, and close supervision, as well as the immediate staff response, and staff supervision requirements during the use of precautionary observation. The policy details the referral, communication, notification, and documentation process. A review process is outlined for serious suicide attempts or serious self-inflicted injury, and a mortality review. The requirement of six hours of annual in-service suicide prevention training for staff was cited in the program's policy as well as the pre-service training, lectures, and practical applications to address suicide precautions, levels of supervision, crisis response, documentation, signs and symptoms of suicide. The policy also outlines the procedures for placement of a precautionary observation youth in a secure observation room.

3.11 Suicide Prevention Services (Critical)	Limited 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.*	

Seven youth mental health records were reviewed for suicide prevention services. The program's policy is for each youth to be placed on precautionary observation until the completion of an Assessment of Suicide Risk (ASR). Six ASRs completed at intake were reviewed and each record contained a completed ASR on the date of the youth's admission. Each youth was placed on constant supervision as a result of the ASR screening. One youth had two instances of the initiation of precautionary observation after admission and each instance required a follow-up ASR. Each of the two follow-up ASRs was completed prior to the

youth being stepped down to close supervision. Each ASR and follow-up ASR for each of the seven youth documented the date and time a conference was held with the program director/designee and the licensed mental health professional (LMHP) prior to youth's supervision being reduced to constant or close supervision. Each ASR documented the parent/guardian, and the juvenile probation officer (JPO) were contacted. Precautionary observation was authorized in each record. Each ASR was completed on the Department's Mental Health and Substance abuse (MHSA) form 004 and completed within twenty-four hours of the referral, concern, or admission. Each ASR conducted at the time of the youth's admission was completed by a non-licensed mental health staff and was reviewed and signed by the licensed mental health staff. In one record, the follow-up ASRs were completed by licensed and non-licensed mental health staff and each were completed prior to the youth's removal from precautionary observation. The program maintains documentation of the non-licensed mental health staff's twenty hours of required training and the five supervised assessments under the direct supervision and within the physical presence of a LMHP. Two of the eight instances of precautionary observation reviewed were applicable for a youth being discontinued from precautionary observation and placed on close supervision. The discontinuation of close supervision was documented in accordance with the program's suicide prevention plan. Each of the records documented applicable alerts with the exception of one instance where the alert was initiated and dated the day after the youth was placed on precautionary observation. The logbook documented the youth's transition from precautionary observation to close supervision, placement back onto precautionary observation, and removal from precautionary observation; however, the program did not document the initial placement on precautionary observation. The program reported they have not had any instances of a precautionary observation youth being placed in secure observation. The program maintains a suicide response kit in master control and the youth dorms. In one youth's record, a suicide alert notification/restriction form documented the youth was initiated on constant supervision, and the licensed mental health professional was contacted; however, the precautionary observation log was started fifty minutes after the youth was placed on precautionary observation. During the time the youth was on precautionary observation, a precautionary observation log documented two warning signs. The notification of warning signs box explained the warning signs displayed by the youth; however, it was not signed by the staff member or the supervisor and the log did not document the program director/designee or mental health were contacted and notified of the warning signs. The facility logbook was reviewed and did not document the event, or any notifications being made. The following day a follow-up ASR was completed; however, the ASR did not reflect the notification of the warning signs or the recent suicide risk behaviors. Following the completion of the ASR, the youth was transitioned to close supervision.

The program utilizes the Department's MHSA form 006 Suicide Precautions-Observation Log. Each precautionary observation log documented safe housing areas. Each log documented observations at increments no more than thirty minutes with one exception where there was one hour in between of the documented observations. The program has an established review process for a serious suicide attempt or self-inflicted injury, and a mortality review for a completed suicide. The review process is outlined in the program's suicide prevention plan. The review process includes the circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, recommendations for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

Three staff were interviewed and each reported if a youth expresses suicidal thoughts they notify mental health, maintain constant sight and sound, and document the supervision. Two

staff reported they search the youth and the room for sharp objects. One staff reported they also contact the medical department when a youth expresses suicidal thoughts. Two staff reported the suicide response kit is maintained in master control, sub control, and the youth dorms. One staff reported the suicide response kit is maintained in each dorm.

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 utilizes the Department's Mental Health and Substance Abuse (MHSA) form 006 Suicide Precautions-Observation Log. Six examples of precautionary observation instances were reviewed to include ninety precautionary observation logs and close supervision logs. In five youth mental health records the precautionary observation logs were maintained for the duration the youth was on suicide precautions. In the remaining instance, the precautionary observation log was started fifty minutes after the youth was initiated on constant supervision. Each precautionary observation log documented safe housing areas. Each log documented observations at increments no more than thirty minutes with one exception where there was one hour in between of the documented observations. One precautionary observation log documented warning signs were displayed by the youth; however, the log did not document the program director/designee and mental health clinical staff was notified. Twelve precautionary observation logs contained times which appeared written over and ten entries (four on the precautionary observation log and six on a close supervision log), did not contain the staff initials who were conducting the observations. One log did not indicate the observation by staff. Each log was signed by the shift supervisor and mental health clinical staff. The three youth who were on precautionary observation reported staff was with them youth at all times while they were on suicide precautions and they were not left alone for any period of time.

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

A review of the mock suicide prevention drills and mock emergency medical drills were conducted for the past six months. Mock emergency medical drills were conducted at least quarterly on each shift. Seventy-five of the seventy-nine applicable staff participated in at least one quarterly mock drill semi-annually. Drills were conducted on each shift at least once a quarter and each shift had at least two drills which documented the use of cardiopulmonary resuscitation (CPR) and/or automated external defibrillator (AED). Three drills documented the use of the knife-for-life, suicide kit, and the first aid kit. The mock drills included the use of 9-1-1 and contacting other staff or medical for support. Six clinical staff training records were reviewed and each clinical staff completed two hours of suicide prevention training in the Department's Learning Management System (Skill Pro) and four hours of instructor led suicide prevention training in 2018. Two staff completed the training as part of their pre-service training and four staff completed the training as part of their annual in-service training. Seven pre-service training and six in-service training records revealed each staff member completed the required six hours of suicide prevention training. One in-service training record reflected the completion of two hours of suicide prevention training in the Department's Learning Management System (Skill Pro); however, the staff member was missing the four additional hours of instructor led training.

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

The program has a written crisis intervention plan which is maintained separately from the emergency mental health and substance abuse services plan. The crisis intervention plan details the response to youth in crisis in the least restrictive method possible and to protect the personal safety of the youth and others while maintaining control and safety of the program. The policy was reviewed by the designated mental health clinician authority (DMHCA) on July 3, 2018 and signed by the facility administrator (FA) on February 13, 2019. The plan details the notification and alert system, the referral process to include a youth's self-referral, communication, supervision levels and requirements, documentation, and a review process.

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 has a crisis intervention plan to respond to youth in crisis in the least restrictive methods possible, to protect the personal safety of the youth and others while maintaining control, and safety of the program. The program completed one crisis assessment during the annual compliance review. The crisis assessment was completed within twenty-four hours based on the needs of the youth. The assessment included the event the youth was determined to be in crisis, the reason for the crisis assessment, method of assessment, current mental status, the degree of dangerous the youth presents to themselves or others, the initial clinical impression, and treatment recommendations. The crisis assessment included the recommendations for follow-up or further evaluation, notification to the parent/guardian, and indicated no change in supervision. The crisis assessment was completed immediately and conducted by the designated mental health clinician authority (DMHCA) who is a licensed mental health counselor (LMHC). A mental health alert was not applicable as the youth was not placed on precautions following the completion of the crisis assessment.

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

The program has a written emergency mental health and substance abuse plan which was signed by the designated mental health clinician authority (DMHCA) on July 3, 2018 and by the facility administrator (FA) on February 13, 2019. The plan outlines the immediate staff response, notifications, communication, supervision, and authorization to transport for emergency mental health and substance abuse services. The plan includes the procedures of transportation for emergency mental health and treatment for a Baker Act, and transportation for emergency substance abuse assessment and treatment under a Marchman Act. The policy and procedures include the documentation, training, and review process. The policy identifies the locations for a Baker Act to include Halifax Behavioral Services in Daytona Beach and the Mental Health Resource Center North in Jacksonville. The policy identifies Flagler Hospital in St. Augustine as the location for a Marchman Act services.

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 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 contracts with a licensed osteopathic physician (DO) to serve as the designated health authority (DHA). The DHA has a specialty in family medicine and is contracted to be on-site at least one hour a day, Monday through Friday. The DHA is scheduled to be on site an additional two hours a week and available for consult twenty-four hours a day, seven days a week. The contract outlines the services to be provided. The program also contracts with another DO to cover for the DHA when on vacation or unavailable. The DO providing coverage also has a specialty in family medicine. Sign-in logs confirmed the DHA or the DO who provides coverage was on-site Monday through Friday, for the past six months. Documentation showed the DHA attends quarterly meetings with the facility administrator (FA), health services administrator (HSA), and the pharmacy consultant. A review of seven youth individual healthcare records and other documentation of healthcare services confirmed the DHA provides oversight for all healthcare services at the program.

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

Healthcare facility operating procedures (FOP) were reviewed and signed in July 2018 by the designated health authority (DHA) and former facility administrator (FA). The current FA reviewed and signed the FOPs in January 2019.The reviews were documented with a cover page listing signatures of the FA, and all medical staff including the DHA. Individual policies and procedures were signed by the DHA and FA. The psychiatrist signed the healthcare FOPs related to psychiatric care and psychotropic medication monitoring. The DHA reviewed and signed cover pages for the nursing protocols and treatment protocols in July 2018. All nursing staff signed a cover page acknowledging a review of the nursing protocols as well. The program developed an orientation for all newly hire healthcare staff, which includes a review of the Department's healthcare policies and procedures. One youth was eighteen years of age and an original AET was signed by the youth. The remaining youth was in the custody of the Department and Children and Families (DCF) and a signed court order was in place. All seven AETs were signed by a parent, guardian, judge, or eighteen years old youth along with a DJJ representative.

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.	

Seven youth individual healthcare records (IHCRs) were reviewed. Five records contained an Authority for Evaluation and Treatment (AET) form signed by a parent/guardian and one had a court order authorizing care for a youth in the custody of the Department of Children and Families (DCF). In the remaining IHCR, there was an AET signed by the youth's guardian but the guardian passed away prior to the youth's admission to the program. The program made multiple attempts to contact the Department of Children and Families (DCF) and the youth's

parents. A court order authorizing care or an AET signed by the parents was not obtained. During the review, contact was made with the youth's assigned juvenile probation office (JPO) and a court order authorizing assessment and treatment was obtained. An interview with the nurse indicated the nurse was familiar with the process of reviewing AETs upon admission and obtaining an AET.

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

Seven youth individual healthcare records (IHCRs) were reviewed for parental notifications. Requests for consent for off-site dental care and administration of over-the-counter (OTC) medication in accordance with the designated health authority's (DHAs) protocols were sent to parents/guardians at the time of admission. Documentation confirmed written parental notifications were completed when youth were prescribed new medication, received off-site care, received periodic evaluations for chronic conditions, or seen by the dentist. Telephone contacts or attempted telephone contacts with parents/guardians were documented for new medications, x-rays, and emergency care. Nursing staff log when notifications are made or attempted by telephone documented a witness for the notification. An interview with the nurse indicated the nurse was familiar with the parental notification requirements.

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

Seven youth individual healthcare records (IHCRs) were reviewed and five youth were taking psychotropic medication(s). One youth was pending consent to start psychotropic medication. An acknowledgement of receipt of the Clinical Psychotropic Progress Note (CPPN) along with page three of the CPPN was sent to the parent/guardian each time the psychiatrist recommended a new psychotropic medication or an adjustment to or discontinuance of an existing psychotropic medication. Psychotropic medications are not initiated until written consent from the parent/guardian is obtained unless the psychiatrist determines the medication is needed immediately, in which a witness verbal consent is obtained. Notifications were sent along with page three of the CPPN for monthly medication monitoring as well. The nurse interview reflected the practice.

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

The program has a policy and procedures addressing immunizations. A review of seven youth individual healthcare records (IHCRs) found each youth's immunization records were reviewed by nursing staff upon admission. The initial progress note completed by the nurse conducting the admission documented each youth's immunizations was current. An interview with the nurse indicated there were no youth in the program needing immunizations during the annual compliance review period.

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

Seven youth individual healthcare records (IHCRs) were reviewed. A Facility Entry Physical Health Screening (FEPHS) form was completed by a nurse on the date of the youth's admission in each record. All sections of the FEPHS form and the body chart were thoroughly completed. The nurse was interviewed and confirmed the process for the completion of the FEPHS at the time of admission.

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

The program has an alert list identifying alert information for all youth in the program. Side effects and precautions for medication are listed on the medication administration records (MARs) for each youth. Dietary alerts are provided to the kitchen staff. A review of seven youth individual healthcare records (IHCRs) found alerts in the records were accurately identified on the alert list and the Problem Lists were updated to reflect current alerts. The alerts were also accurately reflected in the Department's Juvenile Justice Information System (JJIS). Nursing staff can only update medical alerts. An interview with the nurse and six staff described the alert process and reported alerts are updated daily.

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

The program has a healthcare orientation packet which is reviewed with youth upon admission to the program. The orientation packet addresses all required elements for healthcare orientation to include how to access sick call, medical emergencies, medication administration, and instructions to notify staff of any chest pain, shortness of breath, or other similar difficulties. Youth are also informed of what to do in the event of a sexual assault or attempted sexual assault, the right to refuse care, and the non-disciplinary role of healthcare staff. Seven youth individual healthcare records (IHCRs) were reviewed and each youth IHCR documented a nurse reviewed the healthcare orientation packet with the youth on the day of admission. Each youth and the nurse providing the orientation acknowledged the healthcare orientation by signature.

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

The program's practice is to notify the designated health authority (DHA) of each youth's admission regardless of their condition(s). A review of seven youth individual healthcare records (IHCRs) found the DHA was notified of each youth's admission. The notification was completed by the nurse completing the admission process and was documented in the initial progress note, and a form developed specifically for the DHA notification. The notification documented if

the youth had any chronic conditions and/or if the youth was taking medications. The psychiatrist was notified if a youth was taking psychotropic medication.

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

The program has a policy and procedures requiring the completion of an admission healthcare screening when a youth has a change in custody and returns to the facility. The interview with the nurse revealed the nurse was able to confirm the policy. In the seven youth individual healthcare records reviewed, there were three examples of a youth having a change in custody. A new Facility Entry Physical Health Screening (FEPHS) was completed by a nurse upon the youth's return to the program in each case.

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

Seven youth individual healthcare records were reviewed for the completion of a Health-Related History (HRH). A new HRH was completed by a nurse on the date of the youth's admission in each youth's record. The designated health authority (DHA) reviewed the HRH prior to the completion of the Comprehensive Physical Assessment (CPA) and documented their review on the HRH and the CPA in each case. Updates to the HRH were completed when a youth's condition changed. The interview with the nurse confirmed this practice.

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

Seven youth individual healthcare records were reviewed for the completion of a Comprehensive Physical Assessment (CPA). The program's policy, procedures, and practice is to complete a new CPA on each youth, even if a current CPA is available in the commitment packet. Each record contained a current CPA in the commitment packet and a new CPA was completed at the program within seven days by the designated health authority (DHA). All sections of the CPAs were addressed and documented in accordance with Department requirements. When a youth declined parts of the CPA, the term "youth declined" was written next to the section and the youth signed to reflect the refusal. The interview with the nurse confirmed the practice and indicated CPAs are updated annually.

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

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

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

Seven youth individual healthcare records (IHCRs) were reviewed for tuberculosis screening. A Tier I tuberculosis screening was documented by a nurse on the Facility Entry Physical Health Screening (FEPHS) in each record. The date of the most current tuberculin screening test (TST) completed prior to admission and the results were documented on the Comprehensive Physical Assessment (CPA) and on the Infectious Communicable Disease (ICD) form in each case. Based on the program's policy, two youth required an annual update to the TST after their admission which was completed and documented on the ICD form in each case; although, one was completed approximately three weeks beyond a year. In this case, the youth had multiple Tier I tuberculosis screenings completed by nurses prior to the annual due date meeting the Department's requirement, as the youth had multiple changes in custody. The interview with the nurse revealed the nurse was aware of the requirements for a current TST at admission and annual updates.

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

Seven youth individual healthcare records were reviewed. A sexually transmitted infection (STI) screening form was completed by a nurse on the day of each youth's admission and reviewed by the designated health authority (DHA). All seven youth were referred for and received a STI testing. The STI testing results were documented on the Infectious Communicable Disease (ICD) form and filed in the lab section of each IHCR. The nurse was able to identify the STI screening requirements.

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

Human immunodeficiency virus (HIV) testing is provided on site by a registered nurse (RN) who is 501 certified to provide HIV testing. Seven youth individual healthcare records (IHCRs) were reviewed and each youth was offered a HIV testing upon their admission. Three of the seven youth consented to testing and were tested. Pre-test and post-test counseling were documented on the Health Education Record (HER) by the 501 certified RN for each youth. Test results were appropriately filed in each youth's IHCR in a sealed envelope marked, "confidential." The nurse was interviewed and able to explain how HIV services are provided at the program. All interviewed seven youth indicated they could request a HIV test.

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

Sick call is offered twice a day in the clinic at 9:00 a.m. and 1:00 p.m. There is a separate office in the clinic to ensure privacy when care is provided. Only registered nurses (RNs) or the designated health authority (DHA) provide sick call care. Sick call request forms are available to

youth in each dining room. Youth complete sick call request forms and place them in a secured box. Nursing staff check the sick call boxes twice a day on a daily basis. There were no youth presented with a similar complaint three times in a two-week period and no youth made a complaint in which staff were unfamiliar. All sick call requests were addressed within twenty-four hours. Seven youth were interviewed and six reported they could see a nurse immediately or within one day of submitting a sick call request. One youth reported they could see a nurse within three days. All youth said they could see a doctor or dentist, when needed. The interview with the nurse confirmed the frequency of sick call, the process for youth completing sick call forms, and nursing staff checking the sick call boxes daily.

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

Nine instances of sick call were reviewed and each was completed by a registered nurse (RN). All sick calls were documented in the Subjective, Objective, Assessment, and Plan (SOAP) format and reflected the required elements such as vital signs, education, and care provided. All sick calls were documented in the sick call log and on the individual youth sick call index forms. Youth signed their sick call request after care was provided, documented, and acknowledging the care provided. Six staff were interviewed and all reported sick call care is provided by nurses. A sick call was not able to be observed during the annual compliance review.

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

Three youth were reviewed for controlled observation. A Health Status Checklist was completed in each case noting if the youth had any medical alerts and if the youth was taking medication. One youth was in controlled observation for more than four hours. Documentation showed the youth received medical services while in controlled observation, to include receiving the prescribed medication. The nurse was interviewed and reported youth receive care while in controlled observation.

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

An interview with the nurse indicated almost all care provided is through episodic care as nurses are on-site at all times and youth are taken to medical when injured or have a medical complaint. All episodic care is provided by nursing or if on-site, the doctor. Seven youth individual healthcare records (IHCRs) were reviewed which included thirty-one instances of episodic care. Each episodic care event was documented by a nurse in the Subjective, Objective, Assessment, and Plan (SOAP) format. The nurse documented instructions for the youth in all cases and the youth were referred for additional care, if needed. A follow-up with the youth following episodic care was documented within twenty-four hours in each case. All instances of episodic care and the twenty-four hours follow-up were documented in the episodic care log. The first aid kits were observed and contained all required items.

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

The program provided documentation of announced and unannounced emergency response and mental health drills utilizing an internal program form. Drills were completed three times a month on each shift from September 2018 to February 2019. Suicide, first aid and cardiopulmonary resuscitation (CPR) were demonstrated at least once each quarter. A review of the nurses and fourteen staff training records indicated each obtains current certifications in first aid, CPR, and the use of an automated external defibrillator (AED). There are two AEDs on-site stored in the medical clinic and in C Dorm. The AED pads and battery were changed on May 18, 2018. The AED battery expires May 2022 and the pads expires August 2019. A test of both AEDs was completed in front of the monitor and was in working order. A list of emergency numbers is kept in master control and medical. All staff were trained on the use of the epinephrine auto injector on December 20, 2018.

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

Seven youth individual youth healthcare records (IHCRs) were reviewed which included nine instances of off-site care. A Summary of Off-Site Care form was completed by the off-site provider in each case and discharge paperwork was completed if additional instructions were needed. The designated health authority (DHA) reviewed each Off-Site Summary of Care form and discharge paperwork. Follow-up care was scheduled, when needed. Parental notification for off-site care was documented in each case. The nurse was able to explain the procedures for off-site care and tracking follow-up for additional care, as needed.

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

Seven youth individual healthcare records (IHCRs) were reviewed which included four youth with chronic conditions. The four applicable youth was evaluated by the designated health authority (DHA) within a week of their admission. Periodic evaluations were tracked and scheduled using an excel document maintained by nursing. There is also a calendar posted and an appointment book in the clinic identifying dates for periodic evaluations. The interview with the DHA and review of program policy and procedures indicated youth with chronic conditions have periodic evaluations every two months, exceeding the Department's requirement to conduct the evaluations every three months. The review of the four applicable IHCRs confirmed the periodic evaluations were completed every two months. The interview with the nurse confirmed the process.

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

Seven youth individual healthcare records were reviewed which included five youth who entered the program with prescribed medication. All youth were in a Department detention center prior to being transported to the program by detention staff. Nursing staff received the medication(s) and documented verification of the medication(s) in the admission progress note. The medication verification was also documented on a program form in the four youth IHCRs. The nurse notified the designated health authority (DHA) of the medication in each case and the psychiatrist was notified of each youth admitted with psychotropic medication. Each youth continued to receive their medication(s) as prescribed after admission. The nurse interview clearly explained the medication verification process.

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

Seven youth individual healthcare records (IHCRs) were reviewed which five youth were taking prescription medication. Current valid medication orders were in place for each prescription medication and over-the-counter (OTC) medication taken on a regular basis. Medication orders were updated when medication monitoring or chronic condition evaluations occurred. Youth admitted with medication continued the medication in accordance with the existing order following consultation with the designated health authority (DHA) or psychiatrist. There were standing orders for OTC medications covered under the Department's Authority for Evaluation and Treatment (AET). The interview with the nurse indicated the nurse was able to explain the process for obtaining orders for medications.

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

The program has a policy and procedures to address medication storage, access, inventories, and disposal. Only nursing staff have access to medication, as the program has twenty-four-hour nursing. The program has a modified Institutional Class II Type B pharmacy permit. Documentation showed a consultant pharmacist made quarterly visits to review medication storage and disposal of discontinued or expired medications, to include controlled medications. Unused non-controlled medications are returned to the pharmacy for credit. Documentation showed there were at least two witnesses when the pharmacist disposed of the medication(s).

All medications (prescription, over-the-counter, controlled) are stored in the clinic with active medications stored in a secured medication cart and bulk or extra. Patient-specific prescription medications (in pill packs) are stored in cabinets. Controlled medications are stored in a locked box within a double-locked medication cart. Medications are stored separately by type (oral, topical, nasal sprays, injectable, and eye drops) and by youth. There is separate refrigerator for medication requiring refrigeration which is kept in a locked closet in the clinic. All medication storage was clean and organized. All sharps are secured in a locked cabinet. The nurse was able to fully explain the process for storage, inventories, and disposal of medication and sharps.

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

The program maintains active and bulk supplies of over-the-counter (OTC) medications. Separate inventories are completed for the active and bulk supply OTCs. Documentation showed the bulk supply of OTC medication is inventoried at least weekly and continuously when medication is removed to replenish the active supply. Documentation showed the active supply of OTC medication is inventoried continuously with the perpetual inventories occurring at least weekly. Documentation showed sharps are inventoried at least weekly and continuously when sharps are used. Three active OTC medications, three bulk supply OTC medications, and three sharps were counted in the presence of a member of the review team. The counts for each medication and sharp matched the ending inventory documented by the program. The program has a policy and procedures in place to correct and report inventory discrepancies.

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

The program has a policy and procedures to address the storage and inventories of controlled medications. All controlled substances are kept in a locked box within the secured medication cart. Documentation showed controlled medication inventories were documented when the medication was administered and for each shift. The shift-to-shift inventories documented nursing staff signatures for each shift. Three controlled medications were reviewed and the inventories for each controlled medication was accurate. Documentation of disposed controlled medications showed inventories were maintained pending the disposal of the medication. The nurse interview reflected the process for storage and inventory of controlled medications. The nurse maintains all documentation of consultant pharmacist visits which reflected the review and disposal of controlled medications.

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

Medication Administration Records (MARs) were present for each of the applicable youth. The MARs are completed by month with MARs developed for prescribed medication(s) and over-the-counter (OTC) medications administered based on standing orders. The MARs are pre-printed by the pharmacy. Nursing staff will add to the MARs if new medications are prescribed or if orders are changed during a month. Each MAR included all required information to include the youth's name, Department identification number, date of birth, allergies, precautions, and medical grade. The MAR binder includes a large picture of each youth next to their MAR. The start and stop dates were documented for each medication with the dates being updated or corrected by hand when orders were updated. Monitoring for side effects was documented each time medication was administered. Observation of medication pass indicated the nurse asked each youth about the side effects when administering the medication to the youth. The nurse interview confirmed the process for obtaining and maintaining MARs.

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

The program has twenty-four hour nursing in which all medications are administered by nursing staff. A review of Medication Administration Records (MARs) indicated licensed healthcare staff appropriately documented medication administration, to include refusals. The program did not have youth on parenteral medications during the annual compliance review period. Medication administration was observed. The medication cart was placed in the doorway of the dorm and only the nurse had access to the medications. A staff member remained on the other side of the cart in the dorm with the youth. The youth approached the medication cart one at a time. The nurse prepared each medication after the youth stated their name and their identity was confirmed. The nurse observed each youth swallow their medication and swabbed their mouth with a Q-tip to ensure the medication was swallowed. The staff also observed each youth's mouth and swabbed their mouth with a Q-tip to ensure the medication was swallowed. Monitoring for side effects was documented each time medication was administered. Youth were then given a snack to eat after consuming their medication. Six staff were interviewed and all six reported the nursing staff administers medication.

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

The program is required by contract to provide nursing staff on-site twenty-four hours a day, seven days a week. The policy and procedures states licensed medical staff will be on-site twenty-four hours a day, seven days a week to administer medication to youth; therefore, this indicator rates as non-applicable.

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

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

Seven youth individual healthcare records were reviewed and five youth were taking psychotropic medication at the time of their admission. An initial psychiatric evaluation was completed on each youth taking psychotropic medication within fourteen days of admission. The remaining two youth had an initial psychiatric evaluation completed within fourteen days of a referral for psychiatric service. Psychotropic medication monitoring was completed by a psychiatrist at least monthly for each youth. All required information was documented on the

CPPN for each monthly monitoring including the initiation of new psychotropic medication, adjustments or discontinuations of existing medications, targeted symptoms, and side effects. Documentation indicated new psychotropic medications were not started until written parental consent was received or witnessed by verbal consent due to the youth needing the medication, immediately.

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

Infection control surveillance, screening, and management is addressed in the program's policy and procedures and exposure control plan. The procedures address prevention, containment, treatment, and reporting requirements for infectious disease. The procedures address common self-limiting illnesses, common contagious illnesses, serious infectious diseases, Hepatitis A, B, and C, lice, scabies, methicillin-resistant staphylococcus aureus (MRSA), foodborne illnesses, bio-terrorism agents, chemical exposure, and other conditions caused by any other infectious agents. The procedures outline potential exposure for employees. Staff are offered a Hepatitis B vaccine during new hire orientation which is documented on a form and acknowledged by a staff signature. Procedures address access to personal protection equipment and observations confirmed staff have access to gloves and other safety equipment. The designated health authority (DHA) reviewed the infection control procedures and exposure control plan in July 2018.

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

A review of seven youth individual healthcare records found each youth received education on infection control upon admission during the medical intake process. The education included hand washing techniques, personal hygiene, dental hygiene, respiratory etiquette, vaccinations, accident prevention, types of blood borne diseases, and prevention and transmission of communicable diseases. The education was documented on the Health Education Record (HER) and forms which included the infection control information. The education was acknowledged by the signatures of the nurse providing the education and the youth. A review of fourteen staff training records found all staff received training on infection control and the program's exposure control plan. The nurse interview confirmed the health education processes for youth and staff indicating infection control training for staff is conducted annually by a medical professional.

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

The program's exposure control plan meets Occupational Safety and Health Administration (OSHA) and Department requirements. The plan was reviewed and signed by the designated

health authority (DHA) in July 2018. The plan includes risk assessment and methods of compliance. There has not been an occupational exposure at the program and no incidents involving quarantining or hospitalization of staff and/or youth during the annual compliance review period. In the event of staff or youth exposure, the plan requires medical records are maintained for thirty years. An interview with the facility administrator (FA) indicated the exposure control plan is located in the plant manager's office and the clinic. The nurse interview indicated medical staff provide training on the exposure control plan to staff annually, which was confirmed in a review of the staff's training records.

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

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

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

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

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

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

Standard 5: Safety and Security

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

Observations were made of staff during daily activities such as school, recreation, meals, and line movements for each day of the annual compliance review. Staff were actively supervising youth during observed activities. No noted issues or concerns regarding youth supervision were observed. The program maintained a one to eight ratio during day time operating hours. Night time operations were also reviewed via video, the program maintained a one to twelve ratio during this period. The staff appeared to have positive interactions with youth during the observed activities. Staffed used their radios to call master control for clearance to move youth during daily activities. All movement was documented in the master control logbook. Staff had knowledge of the program's written policy and procedures concerning youth supervision and was aware of the protocol when the count was incorrect. The program considers active supervision as the primary function of direct care staff which is to provide supervision of youth to maintain a safe, secure, and humane environment within the program. Staff shall promote safety and security by maintaining active supervision of youth to include interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing behavior of youth and changes in behavior, and consistently applying the program's positive performance system. In addition, the expectation is the program will maintain and document an accurate count of youth assigned to the program and maintain effective systems of determining the number and locations of all assigned youth at all times. All staff will know the exact number and the location of all youth for whom they are assigned to supervise at all times. The program had a full schedule of activities planned for the youth. The daily activity schedule was posted throughout the program areas and available to youth in each living dormitory. Youth were observed participating in a full schedule of activities. Staff continually monitored youth behaviors for any changes which might need to be addressed. There was consistent application of the behavior management system being demonstrated by staff. Staff accounted for youth under their supervision at all times. Staff were observed accounting for youth under their supervision always. Staff were also observed accompanying youth. There were no youth observed roaming free and without staff supervision. Staff also accounted for youth while they were sleeping in their rooms. A staff was asked to explain the procedures if a count was not able to reconciled. Staff reported the program will conduct an emergency count until the count is correct.

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

The program has a behavior management system (BMS) known as the positive performance system which is designed to foster compliance with program rules and teach youth alternative pro-social methods of dealing with problems, utilizing both rewards and a system of progressive discipline. The BMS is designed to assist youth in understanding the program rules and expectations and help youth to manage their own behavior and learn more about acceptable and unacceptable ways of dealing with problematic situations. The BMS places an emphasis on rewards and positive reinforcement and is responsive to the unique characteristics of the program's population. Staff act as pro-social role models for the youth they supervise. Youth shall abide by the rules of the program, and staff enforce rules fairly and consistently. Youth who choose to use unacceptable behavior, is subject to the program's progressive disciplinary system. Sanctions for violations shall be proportionate to the violation; however, corporal punishment shall never be used nor threatened. Staff shall make all reasonable efforts to prevent or reduce the need to use physical force. Physical or verbal abuse of youth is absolutely prohibited. The program's BMS may be revised in detail from time to time which is described in the youth handbook, in which all youth receive during orientation to the program upon their admission. The BMS will accompany the performance planning process including coordination with any individual behavior plan, when applicable. The BMS will always apply a minimum ratio of four positive reinforcements to one negative reinforcement and shall exceed this ratio, whenever possible. The BMS is agreed upon between the program and the school and is clearly written. A review of seven youth case management records documented the youth acknowledged receipt of the youth handbook which includes a review of the programs BMS practices. The rules governing conduct to include positive and negative consequences for behaviors are posted in the youth handbook. The program's BMS practices has not been modified or in the process of changing since the last annual compliance review. During the annual compliance review, observations were made of postings for the programs BMS practices.

The program's written BMS includes provisions to maintain order and security, promote and protect youth rights, address both positive and negative consequences, constructive disciplinary action, and opportunities for positive reinforcement. In addition, the BMS addresses recognition of accomplishments and positive behaviors at a four to one ratio, promotes socially acceptable means for youth to meet their needs, and a process for explaining to youth the reason for any sanctions imposed. The program's written BMS allows for youth to have an opportunity to explain their behavior and for staff to discuss the youth's impact of their behavior on others. Conducting open discussions affords the opportunity for understanding of reasonable reparations for harm caused to others and find alternative behaviors. The discussion held between both youth and staff also promotes positive dialogue and peaceful conflict resolution. When the BMS is applied accordingly, it allows for minimal separation of youth from population. All efforts between the youth and staff allows for implementation and coordination with an individual behavior plan tailored to the specific youth. The program uses an incentive system in which the youth earns rewards based on their behavior. The program uses daily, weekly, and

monthly incentives for the youth to receive rewards. During the annual compliance review, the staff was observed interacting with youth positively and enforcing the BMS.

A total of seven youth were interviewed and asked to explain the difference between each level of the BMS and how they move from level to level. Four youth were not sure or able to explain the differences. The remaining three youth were able to provide an explanation of the different levels of the BMS.

A total of three staff were interviewed and asked to explain the program's BMS practices. Each staff was able to identify the program primarily uses a level system and communicate the youth's role in moving from level to level. Staff were also asked to identify the types of rewards the program offers as part of the BMS. Each staff were able to identify the various incentives offered to promote positive behavior within the program. All three staff agreed items cannot be taken away from youth as a consequence to the youth's negative behavior.

The facility administrator (FA) was interviewed and was able to explain how the implementation of the BMS practices are monitored; however, violations are reviewed and addressed for consistency and/or inconsistency. The assistant facility administrator (AFA) and the youth advocate reviews documentation and grievances concerning the BMS implementation. If necessary, staff will be re-trained and or coached on the proper use of the BMS. The FA was also asked what the BMS is used for, how rewards are monitored, and how the program ensure rewards outnumber the consequences four to one. The FA stated the program utilizes a positive performance system. The positive performance system has levels of which youth earn different incentives and program activities through earned days. The BMS system is driven by treatment progress as evidenced by daily earned days and incentives along with treatment team progress. Higher level achievements include on and off campus activities for youth who pass risk assessments. The recreation therapist utilizes a tracker to monitor rewards. The recreation therapist discusses with the youth any program violations and/or behavior problems which may prevent the youth from earning rewards, daily, weekly, and or monthly. Monthly reward ceremonies have been implemented to highlight youth achievements.

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's written policy and procedures ensures a protocol in which staff is provided feedback regarding their implementation of the behavior management system (BMS). The program director (PD) and the youth advocate oversee the consistent implementation of the BMS. The BMS is tracked by the youth advocate through an excel spreadsheet. The spreadsheet contains a log of the total days earned for each youth, level status, violation report, and the status of earned days by date. Each week, youth level status sheets are posted in the dorms. Youth level sheets and an incentive calendar were observed to be posted in the dorms.

The BMS is reviewed in management team meetings and monthly campus wide meetings for staff and teachers. Sample position descriptions were available for review and included the required qualifications of staff whose job functions included implementation of the program's BMS. The provider's contract included all required parties were involved in the development, implementation, and ongoing maintenance of the BMS. The BMS allows staff to explain the reason for the sanction imposed on a youth and the youth is given an opportunity to explain their behavior. The BMS does not include increased length of stay, denial of basic youth rights, promotion of group punishment, punishment by other youth, or disciplinary confinement. The program does not use room restrictions. Fourteen staff training records were reviewed for BMS training. Documentation reflected seven staff received pre-service training and seven staff received in-service training on the BMS practices.

A total of seven youth were interviewed and asked to explain the infractions or consequences used at the program. All seven youth were able to explain how consequences are earned because of inappropriate behaviors. Additionally, each of the youth were asked to identify rewards used at the program. All seven youth were able to provide examples of incentives or rewards earned because of positive behavior. All youth agreed no youth is ever allowed to punish another youth. Youth were asked to explain how staff are consistent in the use of rewards. Six youth were able to provide an explanation of staff's implementation of rewards. One youth indicated the staff just do it when they want to. Each of the youth were asked how they would rate the program's BMS practices. One youth rated the BMS as very poor, one youth rated it as poor, two youth rated it as fair, two youth rated it as good, and one youth rated it as very good.

A total of three staff were interviewed and asked how youth are informed of consequences and if the youth are able to explain their behaviors. Each staff provided an explanation and supported favorably the ability for youth to explain their behaviors. Each staff was also asked to explain how supervisors provide feedback to staff regarding the implementation of the program's BMS practices. Two staff reported supervisors provide feedback daily from supervisory staff. One staff stated feedback is received during shift briefings.

The (FA) was asked how consequences and violations are monitored. The FA reported violations are tracked and monitored by the recreation therapist, youth advocate, and AFA. A tracker is used to track violations. If a youth has a concern about their consequences, the youth can utilize a "Let's Talk" form and/or the grievance process.

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 total of 192 cameras which stores video footage for thirty days. Thirteen of the 192 cameras are not operational The program has sub-contracted with Village Key to repair the. According to the weekly safety audit, the contractor provided a quote to repair the cameras on February 28, 2019. The program is currently on a minor deficiency for the repair of their camera system; this issue was first identified on April 6, 2018..

The program is required to observe youth at least every ten minutes while in their sleeping quarters. The program operates three separate shifts; the Alpha from 6:00 a.m. to 2:00 p.m., Bravo from 2:00 p.m. to 10:00 p.m., and Charlie from 10:00 p.m. to 6:00 a.m. Past video footage was reviewed for completion and accuracy of ten-minute checks. Observations of six random dates and shifts were conducted for the period of January 28, 2019 through February 23, 2019 All ten-minute checks were documented in real time and staff were observed stopping by each youth room, pausing, and looking into the youth's room. Three staff were interviewed and reported checks are conducted every eight minutes during sleeping hours 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 practicable after order has been restored.* *The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.*	

The program has a written policy and procedures addressing census, counts, and tracking. According to the program's policies, staff are required to utilize the radio to call in all youth movements along with the number of youth under their supervision. Documentation in the program's logbooks reflected counts are being conducted at the beginning of each shift, after each outdoor activity, and during emergency situations. The program also documents total daily census counts, youth movements, new admissions, releases, and when youth are temporarily away from the program. Each of the counts are documented within the program's logbook and highlighted in yellow. Formal counts were observed being conducted throughout the annual compliance review. Informal counts are conducted randomly throughout the day.

Three staff were interviewed and each reported when there is a discrepancy in the count a head count is conducted every two hours, but the program can have random counts at any time. If the count is not accurate, the staff will do a re-count. If the re-count is not accurate, an emergency count is conducted and youth are placed in their rooms, another count is conducted until there is an accurate count, and master control operator calls for emergency count. If the count is not cleared, the facility administrator (FA) comes down and another count is conducted. A search can then start counts are called every three to five minutes. The youth line up by their door, if the count doesn't add up, all the youth are secured in their rooms and the staff will walk around to ensure each youth is in their room and all movement is stopped.

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

The program maintains a chronological record of events, incidents, and activities in a central logbook maintained in master control in accordance with Florida Administrative Code. The program's logbooks were observed to be bound with number pages, not falling apart, or missing any pages. Logbook entries were observed to be made with black ink with no erasure or white out areas. Noted errors were observed to be struck through with a single line, dated, and initialed by the person correcting the error. Each of the entries included the date and time of event, name of the staff, youth involved, brief description of the event, and the name and signature of the staff member making the entry. The program documents emergency situations, incidents including the use of mechanical restraints, special instructions for supervision and monitoring of youth, population counts, security checks, transports away from the program, requests by law enforcement to access any youth, youth placed on controlled observation, admissions, and releases in the logbook. The program highlights specific entries with different colors. The pink highlight is used for youth refusing meals or hygiene. Blue highlight denotes medication pass or identifies the administrative duty officer on-site, date, and time. Green highlight is for noting when searches, new intakes, releases, or transports have occurred. Yellow highlight is used to identify all youth counts. Orange highlight is used to identify any calls to the Central Communications Center (CCC), security alerts, or when youth are placed on controlled or secure observation status. The program uses a purple highlighter to denote the issuance of a gas card.

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*	

A review of the program's written policy and procedures was conducted which identified the system in place to govern the control and use of keys within the program. The written key control policy includes key assignments and usage restrictions, inventory and tracking of keys, secure storage of keys when not in use, procedures addressing lost or missing keys, and the reporting and replacement of damaged keys. The distribution and collection of keys was observed during the annual compliance review. Keys were observed to be stored in a secure storage box which is not accessible to youth. Keys were collected and distributed by the program's master control operator. The master control operator noted issuance of keys by documenting on a daily key log. Observation of the daily key log matched the key rings issued. The program's key storage box was divided into four sections identified as permanent, temporary, restricted, and a visitor key section. The master control operator conducts a key inventory on each shift. The physical plant manager conducts a weekly inspection of keys which are documented on the weekly safety inspections. The physical plant manager also conducts a

separate monthly key inventory. The monthly key inventory binder was available for review. Keys are assigned to staff by department and were observed to be marked with a numbered identification tag. Each set of keys has an assigned key hook. Visitors turn in their keys to the master control operator and are issued a chit with a corresponding hook number. Visitors turn in their chits when exiting the program and receive their personal keys in return. Three random staff members were asked to identify the keys they had on their person and all three staff only had their assigned work keys on their person. The master control operator explained restricted keys are kept separate from all other keys and keys are assigned by department. The master control operator further reported the key and radio logs are maintained by the master control operator and reviewed monthly by the plant manager. The program did not have any instances of lost keys in the previous six months which was verified by the review of internal incident reports and Central Communication Centers (CCC) reports. In the event keys are lost, the program will be immediately placed on lockdown, and a search will be conducted until the keys are found. In the event the keys are not found, the facility administrator (FA) will authorize a change in locks, key locations, and key duplications. Three staff were interviewed and each was able to explain the key issuance process and what to do in the event keys are missing or damaged.

5.08 Contraband Procedure	**Satisfactory Compliance**
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.* *The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement.*	

The program has a written policy and procedures concerning contraband procedures. A review of the program's written policy and procedures aligns with the Department's recommended guidelines for contraband which was distributed in August 2015. The program's system in place is to prevent the introduction of contraband entering the program including items or materials considered to be contraband and any exemptions. Youth are provided with a list of prohibited contraband items which includes cell phones and or equipment (to include electronic devices) which may record either audio or video recordings. The list of contraband items was observed in the youth's handbook. Youth are informed of the consequences if found with contraband. The program's written policy and procedures also address searches of the physical plant, program grounds, youth, incoming and outgoing mail. In addition, the program's written policy and procedures delineates items and materials considered contraband, the avoidance of introduction into the program, documentation of incidents, staff training, actions taken when contraband is discovered, and involvement of law enforcement. The program's written policy and procedures addresses any employee found in possession of contraband in the program will

be subject to disciplinary action, up to and including dismissal. In addition, law enforcement will be contacted if any item found which would be considered illegal as defined in Florida Statutes, or if there is evidence of any type of unlawful activity. The written policy and procedures defines contraband as any unauthorized item determined to be in the possession of a youth or within the program and accessible to youth which poses a threat to the safety, security, and operations to the program. Identified contraband items include but are not limited to illegal items, sharps, escape paraphernalia, drugs, to include prescription or over the counter medication, tobacco products, electronic or vaporless cigarettes, non-program issued electronic equipment or devices, unauthorized food or beverages, metals, cell phones, cash, or keys. Documentation of confiscation of contraband is maintained in the youth's case file. Contraband not considered illegal will be stored at the program until the youth's release or mailed back to the family. The contraband search binders for the previous six months were available for review. Documentation reflected youth room searches are conducted at least once a week, in some instances twice a week.

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

The program has a written policy and procedures addressing searches. Searches were observed throughout the annual compliance review. Youth were observed being searched before and after movement of education and vocational classes, recreation, and movement to and from the dorms. There were no searches observed for an admission or visitation as neither of these events occurred while on-site. A transport was observed in which the youth was observed being searched by staff of the same gender before and after the transport. Groups observed were held in the youth living areas in which youth were observed to be searched prior to moving to and from the living areas. Searches were observed to be conducted by a staff member of the same gender as the youth. Youth were observed being treated with dignity and respect during the observed searches. Searches conducted by staff were conducted according to the Protective Action Response (PAR) training manual. Three staff were interviewed and asked when and how youth searches are conducted. One staff responded youth are search throughout the day, going to restroom, moving from mod to school, and recreation. Searches are done with a pat search where the youth face the wall with their arms out. Another staff stated before every movement. The third staff replied youth searches are conducted by a strip search after every visitation, transport, after off campus activity, during every morning, and every movement. Seven youth were interviewed and reported searches are conducted during the return from an off-campus activity, after outdoor activities, when items are missing, after visitation, after meals, and after work details.

5.10 Vehicles and Maintenance	Satisfactory Compliance

All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment so they may be operated in a safe manner.

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

The program currently utilizes two vehicles for transporting youth. Vehicle maintenance binders were available for review. Invoices for an automotive shop were available for review and reflected both vehicles received an annual safety inspection. One vehicle received an annual safety inspection on January 28, 2019 and the other on December 11, 2018. Both vehicles contained fire extinguishers, approved first aid kits (which were inspected weekly by medical staff), seat belt cutters, window punch, and the appropriate number of seatbelts. Youth are not attached to any part of the vehicle by any means other than the proper use of a seat belt. Vehicles are secured when not in use.

5.11 Transportation of Youth	Satisfactory Compliance

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

The program has a written policy and procedures to ensure the security and safety of youth and the community when youth are transported outside of the facility. Staff are issued a facility cell phone prior to each transport. According to the written policy and procedures, the staff to youth ratio during transportation of youth is one to five. One transport was observed during the annual compliance review in which one youth was transported to an outside appointment. The youth was observed being searched by a staff member of the same gender prior to and returning from transport. The youth was accompanied by two staff members both of the same gender as the youth. Both staff members provided their driver's license for review and both were valid. Both staff and youth were observed wearing seatbelts. Each staff member was in possession of a two-way radio and one was in possession of a facility cell phone. Both vehicles the program utilize to transport youth have a safety screen which separates the driver's compartment from the back seat. A random inspection of personal vehicles in the program's parking lot was conducted and vehicles checked were found to be secured. The program provided an approved driver's list for review. The approved driver's list was also posted in master control. Employee driver's license are checked annually by the human resources manager and updated, as necessary. Three staff were interviewed and two reported they are issued a facility cell phone prior to transport and one reported they had not facilitated a transport. All three staff reported they are not permitted to use their personal vehicles to transport youth.

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

The program has a written policy and procedures to ensure the safe and efficient operation of the physical plant and to protect against the development of conditions which may have the potential to adversely affect the health, safety and welfare of youth, staff and visitors. The written policy and procedures outlines who is responsible for conducting the weekly security audits and safety inspections, the development and implementation or corrective actions warranted as a result of safety and security deficiencies found, and an internal system to verify deficiencies found are corrected. According to the written policy and procedures, the physical plant manager is responsible for conducting weekly safety audits. In addition, the physical plant manager will review the completed form with the facility administrator (FA) and have the FA sign and date the audit form. A review of the security audits found documentation of thirteen of the facility cameras were not working. The program reported notifying Village Key, who is contracted to repair the cameras. The company is providing a quote by February 28, 2019 for the cost to make the repairs needed.

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

The program has a written policy and procedures addressing the issuance, inventory, and control of equipment and tools. Tools are securely stored when not in use. All tools are marked for easy identification. The program utilizes a shadow board in which all tools are outlined. All tools are inventoried prior to being issued for work and following work activities. All tools are inventoried daily such as sharp edged or pointed tools. A daily tool inventory was available for review. Damaged tools were clearly identified on the perpetual inventory, tagged, and will be replaced. The daily inventory matched the actual tools on hand. The program completed a monthly inventory of tools without sharp edges. Machetes, bowie knives, or other long blade knives are prohibited. The physical plant manager reported there has not been any instances of lost tools since the last annual compliance review. A review of seven staff training records reflected staff received pre-service training on the safe use of tools. A review of seven youth records reflected youth receive training on the safe handling of Class B tools upon admission to the program. Seven youth were interviewed concerning the use of tools within the program. All youth reported using mops, brooms, and scrub brushes. One youth stated using handled tools which may be used in maintenance.

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

The program has a written policy and procedures addressing youth supervision during the handling of tools. The procedures outline specific ratios, tools distribution and collection, and search criteria. According to the written policy and procedures, staff to youth ratio is one to five during work projects and vocational activities. Youth in the program can be assigned to assist maintenance and kitchen staff. An approved list of youth was observed in both areas. Each list is updated monthly based on the outcomes of a risk assessment. Each youth on the list was

approved utilizing a risk assessment which is completed on every youth in the program, monthly. The risk assessment binder was available for review. One youth was observed assisting maintenance staff on the last day of the annual compliance review. The youth was assisting maintenance in the replenishment of toiletries throughout the facility. Three youth were also observed assisting kitchen staff with garbage disposal and meal preparation with a staff to youth ratio of four to five. One youth was observed mopping the dining hall floor while one staff observed. Youth were not observed exiting these works areas but were observed upon their entrance at which they were searched by staff. Three staff were interviewed concerning the use of tools by youth. Two staff reported youth only utilize mops, brooms, and scrub brushes. One staff stated youth do not use any tools.

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 addressing outside contractors. According to the written policy and procedure, the physical plant manager will provide the contractor with a Notice of Tool/Equipment instruction prior to any contracted work occurring. The written instructions for contractors include a maintenance staff member will inspect all tools prior to entering the facility, a final inspection of the work site will be completed, at no time should tools be left unattended, limit the tools used to only those necessary to complete the job, sign-in and out of the facility, no items will be given to any youth, appropriate behavior will be maintained at all times, and if a tool is missing immediately notify the facility administrator (FA). The contractor must sign the form indicating receipt of instructions prior to entering the program. The outside contractor binder was available for review. Invoices matched the sign-in dates on the Notice of Tool/Equipment Instructions forms signed by the outside contractor. The forms were observed to be filled out in their entirety. The physical plant manager conducts an inventory of the contractor's tools upon entering and exiting the program. The program's written policy and procedures states the FA may give written approval for staff to bring in electronic communication devices (devices capable of taking pictures), in which an approved list of staff who can bring in these items will be placed in master control.

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 conducts practice drills in order to be prepared for immediate implementation or mobilization of the plan whenever an emergency arises. The program conducts fire, safety, evacuation, and disaster drills. The documentation for the drills included the type of drill, date and time, participants, brief scenario, and findings to include recommendations. The program currently has three shifts. The drill documentation also included pictures of the drills in action, some of which were time and date stamped. In the previous six months, the program was required to complete a minimum of eighteen fire drills. The program completed fifteen of the eighteen required fire drills. Additionally, the program completed an escape and disaster) drill in the previous six months. Observations of fire evacuation routes and egress plans were posted throughout the facility. Upon each youth's admission to the program, the youth signs an orientation checklist indicating they were briefed on egress and evacuation routes, and fire drill procedures. Seven youth were interviewed and four reported they have not been instructed on what to do in the event of a fire. One youth reported having participated in one drill. One youth

reported participating in two drills. One youth stated participation in drills monthly. Three staff were interviewed and reported participation in weather, escape, and fire drills. In addition, staff reported they have participated in medical and suicide response drills.

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

The program has a coordinated disaster plan and Continuity of Operations Plan (COOP). The plan provides 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 COOP is conspicuously posted in the facility, readily available to staff, youth, visitors, and disseminated to the appropriate local authorities. The COOP plan is located in master control, the employee break room, the facility administrator's (FAs) office, and the supervisor's office. The COOP is reviewed and updated annually and was submitted to the Department's residential regional director/designee and signed on May 11, 2018. According to the program director (PD), the COOP is accessible to all staff and is located in master control, the employee break room, the facility administrator's (FAs) office, and the supervisor's 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 addressing the storage and inventory of flammable, poisonous, and toxic items and materials. Flammable, poisonous, and toxic items were observed to be secured at all times during the annual compliance review. All flammable, poisonous, and toxic materials were observed stored in secured areas which are inaccessible to youth. Inventories for these items were available for review and matched the actual items at the program and included corresponding Safety Data Sheets (SDS). Bulk chemical items were observed to be stored in a secured shed in the maintenance area, which is inaccessible to youth. Items used for daily cleaning were observed to be stored in a secured closet within the youth living areas. Items used in the kitchen are stored in a secured closet. According to the written policy and procedures, the facility administrator, assistant facility administrator, physical plant manager, dietary manager, and shift managers are the only staff authorized to utilize these materials.

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

The program has a written policy and procedures regarding youth handling and supervision of flammable, poisonous, toxic items and materials. The program maintains strict control of flammable, poisonous, and toxic items and materials. Youth do not use, handle, or clean up dangerous or hazardous chemicals. Youth do not clean, handle, or dispose of any person's bio-hazardous material, bodily fluids, or human waste. These items are located in a secured closet inaccessible to youth. Youth were observed cleaning in the kitchen and in the dorms during the annual compliance review. At no time youth were observed handling these items. Seven youth were interviewed and six reported never using chemicals or cleaning agents. One youth reported using bleach but stated the staff spray the chemical and the youth wipe it off.

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

The program has a written policy and procedures addressing the disposal of flammable, toxic, caustic, and poisonous items. The written policy and procedures ensures all hazardous materials are disposed of in accordance to the Occupational Safety and Health Administration (OSHA) Standard 29 1910.1030. According to the written policy and procedures, the facility administrator (FA), assistant facility administrator (AFA), physical plant manager, dietary manager, and shift managers are the only staff authorized to handle these materials. These staff received training on the handling and disposal of these items. Medical staff reported the program is contracted with "Stericylce" to dispose of all biohazardous waste and disposals are made on a monthly basis. A disposal log was available for review. The program also utilizes the St. John's County landfill for disposal. The program is also contracted with Advanced Garbage Disposal for the disposal of kitchen grease which according to the physical plant manager is disposed of on an as needed basis. In the event of a chemical spill, staff will immediately notify master control and the shift manager, the area will be assessed and evacuated if necessary, ventilation systems will be shut down, and in conjunction with the FA, a determination will be made on whether to request outside assistance. According to the program director (PD) all contaminated garments or items are disposed of in a bio-hazardous receptacle.

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

Observation of the program's activity schedule was posted throughout the facility and available for review. The schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities for youth. The activity schedule provides for a range of supervised activities, both indoor and outdoor. Outdoor activities include basketball, football,

volleyball, and soccer. Indoor activities include movies, games, and cards. All activities promote social and cognitive skills development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program employs two recreational therapists who meet all position requirements. One recreational therapist holds a bachelor's degree in health and human sciences with a concentration in therapeutic recreation. The second recreation therapist holds a bachelor's degree in Health Science and a master's degree in sports management. A copy of both recreational therapists' credentials was obtained. Both recreational therapists also had evidence of pre-service training in TrueCore Recreational Therapeutic Training. This trained observed was documented within the Department's Learning Management System (SkillPro). A review of the program's logbook reflected recreation is being held in accordance with the daily activity schedule. Recreation was observed on the third day of the annual compliance review. Youth were observed playing football and basketball. A water cooler with cups was observed available to youth during the recreation period. All outdoor recreation activities are weather dependent and youth alerts are reviewed prior to activities to reduce the possibility of heat stress, dehydration, and other issues related to extreme outdoor temperatures. A review of seven youth records reflected therapeutic activities are a part of the youth's performance plan. Youth are able to provide input on program activities through the youth advisory board, weekly dorm meetings, and "Let's Talk" forms. Seven youth were interviewed and each reported they receive at least one hour each day of outdoor recreational activities. The youth stated they participate in activities such as volleyball, basketball, and football. Three staff were interviewed and each confirmed youth participate in activities such as recreational time, soccer, and football. Staff also stated the program has a staff versus youth basketball game at times.

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

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

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

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

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

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

The program's written policy and procedures state the program does not allow youth to participate in water-related activities; therefore, this indicator rates as non- applicable.

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has written established procedures by which the program may provide youth with opportunities to re-establish and maintain family and community ties, to be involved in first-person communications with attorneys and their agents, approved law enforcement, court and DJJ staff, and to ensure control of community access to the program. The program's activity schedule reflects visitation is held every Sunday from 2:30 p.m. to 5:30 p.m. Parents/guardians are mailed the program's procedure for visitation, mail, and phone usage upon the youth's admission to the program. The visitation log was available for review. The visitation log reflected the visitor's name, whether they were an approved visitor, signature, time in and out, identification check, rules provided, searched completed, and the initials of the staff completing the log. The written policy and procedures reflects only the facility administrator (FA) may approval special visits. Youth are allowed to make phone calls once a week and calls are facilitated by the youth's case manager. Observation of the phone call schedules were posted in

each dorm. Phone calls begin after the youth are released from school. Phone calls are initially ten minutes for each youth but can increase with level achievement up to thirty minutes. Phone call logs were available for review and included who the youth was contacting, whether the call was successful, and both the youth and staff initials. Youth are permitted to send and receive letters to those persons on their approved correspondence list. All incoming and outgoing mail is searched by the youth's case manager. Seven youth were interviewed and each reported they have been able to communicate with their families by mail, telephone, and letters.

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

The program has a written policy and procedures to ensure youth are able to control their behaviors in a manner safe to the youth and the facility. The program's controlled observation rooms meet the requirements of the Department of Juvenile Justice. The program had four uses of controlled observation during the previous six months. Three controlled observation reports were reviewed. In each report, there was no documentation of the youth or the controlled observation room being searched prior to youth placement in controlled observation. One report did not reflect the date or time of the youth's release from controlled observation. According to the program's written policy and procedures, staff will search the youth and the controlled observation room prior to placement and document the searched in the narrative portion on the controlled observation report. According to Florida Administrative Rule 63H, both the youth and the controlled observation room will be searched prior to placement.

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

The program has a written policy and procedures to ensure youth are able to control their behaviors in a manner safe to other youth and the facility. The written policy and procedures reflects the program director (PD) designates supervisory or higher-level staff to approve placement of youth in controlled observation. The program had four uses of controlled observation during the previous six months. All four controlled observation reports were reviewed. Documentation in each of the four reviewed reports reflected youth met the requirements of placement in controlled observation. Health status checklists were completed on all three youth. None of the youth were placed in controlled observation for more than twenty-four hours. A healthcare professional completed the health status checklist for each incident. Three incidents documented placement for over two hours. In all three of records, the facility administrator (FA) or designee documented and granted an extension. The supervisory or higher-level staff approved the placement in controlled observation for all four incidents reviewed.

5.26 Controlled Observation Safety Checks Release Procedures	Satisfactory Compliance
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 has had four uses of controlled observation during the previous six months. All four controlled observation reports were reviewed. All reports reflected staff making the placement in controlled observation completed the first page of the report and submitted it to a supervisor. Each of the four reports reflected completion of safety checks to include observations of youth behavior. Staff documented all safety checks and observations on the Controlled Observation Safety Checks form. For all four reports reviewed, the facility administrator, or supervisor gave written approval prior to the youth's release, and staff documented internal alerts as needed. The Controlled Observation Reports, Health Status Checklist, and Observation Safety Checks forms were maintained in an administrative record and within the youth management record. For all four reports, the administrator, or designee approved the release based on a determination of the youth's behavior. There was evidence the facility administrator or assistant facility administrator reviewed/approved the controlled observation within fourteen days of the youth's release from controlled observation to determine the placement was appropriate. In-house alerts were determined and noted by staff when warranted. A review of the program's written policy and procedures for controlled observations determined staff designations for authorization of controlled observation placement.

Program Name: Gulf Academy
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: St. Johns County / Circuit 7
Review Date(s): February 26 - March 1, 2019

MQI Program Code: 1068
Contract Number: R2104
Number of Beds: 56
Lead Reviewer Code: 144

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.07 R-PACT Assessment and Reassessments	5.24 Search and Inspection of Controlled Observation Room
3.11 Suicide Prevention Services*	