STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Gulf Academy

TrueCore Behavioral Solutions, LLC.

(Contract Provider)
765 E. St. Johns Ave.
Hastings, Florida 32145

Review Date(s): January 28 - 31, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Ken Phillips, Office of Program Accountability, Lead Reviewer (Standard 1)
Renette Crosby, Office of Program Accountability, Regional Monitor (Standard 5)
Jill Foy, Office of Program Accountability, Regional Monitor (Standard 4)
Tara Gilligan, Office of Program Accountability, Regional Monitor (Standard 4)
Kristine Harshaw, Office of Program Accountability, Regional Monitor (Standard 1 and Interviews)
Patrick McKinstry, Office of Program Accountability, Regional Monitor (Standard 3)
Courtney Preston, Detention Services, Detention Superintendent (Standard 5)
Marla Vose, Marion Youth Academy, Sequel Youth Services, LLC, Case Manager (Standard 2)

Program Name: Gulf Academy
Provider Name: TrueCore Behaivoral Solutions, LLC.
Location: St. Johns County / Circuit 7
Review Date(s): January 28-31, 2020

MQI Program Code: 1068
Contract Number: R2104
Number of Beds: 56
Lead Reviewer Code: 145

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.17 Educational Access	

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
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Gulf Academy is co-located with Hastings Comprehensive Mental Health Treatment program. Gulf Academy is a fifty-six bed program, for twelve to nineteen year old males, located in Hastings, Florida. The program is operated by TrueCore Behavioral Solutions, LLC., through a contract with the Department. The program also has six beds dedicated to serve male youth who may be classified as needing intensive medical overlay services. The program fosters each youth by providing Thinking for A Change (T4C) curriculum as their primary delinquency intervention. In addition, the program provides the following interventions including Teen Relationships Workbook, Living in Balance, Life Skills 225, Young Men's Work, Anxiety Workbook for Teens, Anger Management, and Thinking for Change (T4C) curriculum. The program has a licensed psychiatrist who is required to be on-site one day each week for eight hours a day. The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. 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 a full-time employee of the program; on-site forty hours a week and on-call twenty-four hours a day, seven days a week, in the event of a mental health or substance abuse emergency. The DMHCA supervises the therapeutic staff. There is combined management team shared between Gulf Academy and Hastings Comprehensive Mental Health Treatment programs. The management team consists of a facility administrator, two 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 provides medical services twenty-four hours each day. There are six registered nurses (RN) employed for both Gulf Academy and Hastings Comprehensive Mental Health Treatment program. Gulf Academy had two vacant registered nurse positions at the time of the annual compliance review. The program contracts with an osteopathic physician (DO) to serve as the designated health authority (DHA). The DHA reported he 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 he is unable to be at the program. Educational services for youth are provided by the St. Johns County School Board. The program has a total of one hundred ninety-two cameras in which all were operational. At the time of the annual compliance review, the program had reported the following number of vacant positions: ten youth care workers, two registered nurses, and one therapist.

Strengths and Innovative Approaches

- Gulf Academy's recreational therapist took youth who earned their off-campus privileges for a series of college tours. At the conclusion of the tours, some of the youth wrote essays about what the tour meant to them, and some were encouraged to apply and were accepted to the university.

- At the beginning of June 2019, the program hosted its first annual mother/son dance as a way to celebrate the youth's mothers and to demonstrate their son's progress in the program.

- In July 2019, Gulf Academy reportedly began utilizing a new Positive Performance System. This system incorporates a daily point card, a daily community meeting, deal breakers and a weekly point store for incentives.

- Youth had an opportunity to participate in a program named Let's Move Jacksonville which was inspired by Former First Lady Michelle Obama. Youth enjoyed healthy foods, dancing, and explored different health booths.

- The recreation therapist held a vision board party for youth to create vision boards focused on where they want to be in life and how they want to achieve their goals.

- During the holidays staff collected toys and donated them to Wolfson's Children's Hospital.

Standard 1: Management Accountability

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

A total of thirteen staff personnel records were reviewed for initial background screening. Seven of thirteen received a completed background screening prior to the staff's hire date. The remaining six staff background screenings were completed and determined eligible after the staff were hired, but only for training and orientation purposes, thus not allowing these staff contact with youth or youth records during this time. All newly hired direct care staff records included the Berke Assessment as the pre-employment assessment tool administered. Passing scores were also available within all staff records. Evidence was also available confirming a criminal history report, Central Communications Center, and Staff Verification System module was reviewed for each of the staff records. The program reported there were no volunteers or interns who required initial background screening during this annual compliance review period. An interview with the program's human resources (HR) manager revealed the program's procedure concerning background screening. The HR manager stated the initial background screening is completed through the Department's Clearinghouse. Central Communications Center information is screened for any staff who previously had worked in youth programs. The program completed and submitted the Annual Affidavit of Compliance with Level 2 Screening Standards on December 6, 2019. Teachers employed by the program receive annual screening as required. The program had no new teachers hired since the previous annual compliance review.

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

The program has a written policy and procedures in place to address initial background screening and five-year re-screening. A review of the staff roster and initial hire dates found no staff required a five-year re-screening during this annual compliance review. One staff, who would require a five-year re-screening by May of 2020, was submitted for a background re-screening January 2020, but results have not been received at the time of the annual compliance review.

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

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

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

The program has an employee handbook which all new staff sign for and receive at the time of hire. The handbook includes a code of conduct for staff to follow. Electronic staff signatures were observed on record to confirm this practice. Observations made during the annual compliance review found evidence the Florida Abuse Hotline and number for the Central Communication Center (CCC) were posted in visible areas for youth and staff. These emergency numbers are also documented within the youth handbook, which is given to each youth upon admission. The program has a written policy and procedures which includes the abuse reporting process. The policy indicates case managers are to inform every youth during orientation of their right to call the Florida Abuse Hotline or CCC, and how to access the telephone. The policy further indicates Chapter 39.201 Florida Statues mandates any person who knows, or has reasonable cause to suspect, a child is abused, neglected, or abandoned by a parent or other caregiver shall immediately report such knowledge to the Florida Abuse Hotline. The program's abuse reporting procedure consist of the following procedures: Program staff are to provide youth with timely telephone access to report any allegations made and verbal notification is made to the shift manager immediately once a youth request to contact the Florida Abuse Hotline or CCC. The shift manager will assist the youth in making the call by dialing the appropriate phone number, and recording the date and time of the call, taking the operator's name and number, and provide the information on an internal report. Youth are permitted to freely communicate with the operator. Staff are to maintain sight and contact with the youth but remain in an area which allows for the youth to freely and confidentially report. Documentation was reviewed of the Trauma Responsive and Caring Environment (TRACE) self-assessment. The facility administrator (FA) reported the TRACE Champions Team meets monthly to discuss pertinent issues. Information is also discussed during all campus meetings. Based on a review of the program's CCC report information received, the program had a total of nine incidents related to allegations made of physical, psychological, or emotional abuse since the last annual compliance report. There were four total substantiated reports related to

physical, psychological, and emotional abuse since the last annual compliance review. For all four incidents, the program's administration and human resources department provided documentation of evidence management took immediate action to address the incidents. Seven staff were interviewed concerning the program's abuse reporting process. Staff reported supervisors are notified and youth are afforded opportunities to call if needed. None of the seven staff reported they have ever heard a co-worker refusing a youth the opportunity to report abuse. When asked if they have ever heard a co-worker using profanity when speaking with youth, five reported no and two reported yes. One stated they have heard this daily, and one staff stated they have heard it just in normal conversation. Seven youth were interviewed and all reported they felt safe in the program. None of the youth reported they have ever been stopped from making an abuse call. When asked if staff were respectful when speaking with them, three stated yes, and the remaining four reported some staff are and some are not. Seven youth were asked if staff have used profanity when speaking with them. Two stated never, two stated occasionally, and three stated often. The youth responded stating staff do this in normal conversation, although one youth stated they use this language when they are mad. The FA was made aware of all youth and staff responses with interviews conducted. For these responses, the FA reported the program takes immediate action when dealing with staff who use profanity when speaking with youth. During the annual compliance review, the FA gave an example where a staff and a therapist were engaged in an argument with each other and verbal profanities were exchanged in the presence of youth, however not directed at any youth. Each of these staff were terminated as a result. Copies of the termination information were obtained from the human resources manager to confirm this, showing management took immediate action to address the issue. The FA further reported staff meetings are consistently addressing, and will continue to address, staff professionalism when dealing and interacting with youth. To ensure staff are knowledgeable in contacting the Florida Abuse Hotline or CCC, the FA reported annual training on the incident reporting process occurs with all staff. In addition to the training, signage is posted throughout the program and on the youth living quarters, so they understand their rights to live in an abuse free environment and what numbers they can call if needed. For tracking purposes, CCC reports and abuse incidents are discussed during every morning meeting, and a CCC report is provided to staff daily, as well as a weekly CCC tracker.

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 facility administration was interviewed and stated two staff have received disciplinary actions due to allegations of abuse towards a youth since the last annual compliance review. However, documentation revealed the program had a total of four incidents requiring management response to allegations of incidents of either physical, psychological, or emotional abuse since the last annual compliance review. For all four incidents, the program's administration and human resources department provided documentation confirming management took immediate action to address the incidents.

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

A review of the Department's Juvenile Justice Information System (JJIS) found the program had twenty-two incidents reported to the Central Communications Center (CCC) for the scope of the annual compliance review. This is a decrease in incidents compared to the previous annual compliance review. A review of the internal grievances and incident documentation provided found no other incidents were required to be reported to the CCC. A sample of five incidents were reviewed for reporting timeframes. All were reported with the two-hour timeframe as required. Four of five incidents were applicable for documenting within the program's logbook. One of these four was not documented in the logbook as required. The facility administrator was interviewed and stated annual training on incident reporting procedures occur with all staff. In addition to the training, signage is posted throughout the program and on the youth living quarters, so they understand their rights to live in an abuse free environment, and what numbers they can call if needed. For tracking purposes, CCC reports and abuse incidents are discussed during every morning meeting, and a CCC report is provided to staff daily and 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.	

The program has a Protective Action Response (PAR) plan which was submitted to and approved by the Department on March 28, 2019. Based on review of PAR information provided and documented, the program has experienced an increase in the total number of PAR incidents for this annual compliance review period. An interview with the program's facility administrator (FA) revealed incidents contributing to the increase include a major disturbance the program had in December 2019, when multiple youth were involved in a physical altercation resulting in numerous PAR incidents. Additionally, the FA stated the program has experienced an increase of youth admissions from Dade County at one time, which attributed to behavioral problems. As a result, the program has begun submitting transfer requests to separate problematic youth to other programs. Based on documentation received from PAR reports and data maintained by the program, the total number of PAR incidents have begun to decrease for the past month prior to the annual compliance review. The program's PAR rate during the annual compliance review period was 2.13, which is below the statewide Residential PAR rate of 2.35. A sample of five PAR incidents were reviewed for completion requirements. A review of the incidents and documentation found each report was completed by the end of the staff member's workday and included statements from all staff involved. The incidents did not indicate any injuries to staff or youth and did not require a Mechanical Restraint Supervision Log. Each PAR incident was documented as reviewed by a PAR certified instructor. For all five reports reviewed, a Post-PAR interview was conducted with the youth and the administrator, or designee no longer than thirty-minutes after the incident. The report information was reviewed by the FA within seventy-two hours of the incident as required. A copy of the PAR reports were

placed in a centralized file within forty-eight hours of being signed by the FA. The FA was interviewed and stated the chief of security reviews all PAR incidents by video surveillance. All incidents are discussed during the morning management meetings. During all campus meetings, staff discuss ways to avoid using physical interventions and emphasize the use of verbal de-escalations.

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

Seven staff training records were reviewed to verify pre-service training requirements. All seven staff were certified within 180 days of hire and completed over the required minimum 120 hours of pre-service training. All had certifications for cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR) training, Professionalism and Ethics, Suicide Prevention, Emergency Procedures, Prison Rape Elimination Act (PREA), and Active Shooter Training. Six of seven had training in Child Abuse Reporting Procedures. One staff completed the Child Abuse Reporting Procedures training two months after their hire date. In addition to these trainings, the program's pre-service training requirements included training for Adolescent Behavior and Development, Trauma Informed Care, and Universal Precautions. All seven staff training records included evidence each staff had these additional trainings. All but one staff had the required trainings documented within the Department's Learning Management System (SkillPro). One staff training records found evidence some trainings were not captured within SkillPro, but documentation of the completed training was presented and observed. The instructors completing the training are qualified to do so, as reflected in each trainer's 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 course names, descriptions, objectives, and training hours for any instructor-led training. The pre-service training plan was submitted on March 13, 2019 and approved by the Department on April 12, 2019.

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

Seven staff training records were reviewed to verify the in-service training requirements. The staff positions were three youth care workers, one therapist, a unit manager, and two administrative staff. Six of seven staff received more than the required twenty-four hours of in-service training. There was one exception, one youth care worker did not complete cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED) during 2019. The staff's certification for this training was current however, as the certification does not expire for two years. This staff completed only seventeen hours of in-service training. All seven staff completed Protective Action Response (PAR) update training. Five of seven staff received six hours of suicide prevention training to include two hours in the Department's Learning Management System (SkillPro), and four hours of instructor led training. There were two exceptions where staff received part of the training, one staff completed four hours of instructor

led training, and the other staff only received the two hours of SkillPro training. All three staff in supervisory positions completed a minimum of eight hours of additional training in the areas of management, leadership, personal accountability, employee relations, communication, and/or fiscal training. Seven of seven staff records reflected the in-service and supervisory training is documented in SkillPro. The instructors providing the training are qualified to do so, as reflected in each trainer's instructor certification. The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training, which included course names, descriptions, objectives, and training hours for any instructor-led training. The in-service training plan was submitted on March 13, 2019 and approved on April 12, 2019.

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 policy and procedures addressing the grievance process. The policy indicates any youth requesting to file a grievance be given the proper forms, assistance, and instructions on the preparation and submission of a grievance. The policy includes all staff are to be trained in the grievance process. A review of seven pre-service staff training records found six of seven received grievance response training as required, the other staff did not. According to the program's in-service and pre-service training plans, training for the grievance process is only required in pre-service training. The program's grievance process includes an informal, formal, and appeal phases for youth to submit a grievance. In the informal phase, youth are first encouraged to attempt to talk over the problem with the staff member directly involved, or the shift supervisor, in an attempt to resolve the issue. Youth are provided Speak Out forms, where they can document issues they may have. These forms, along with grievance forms are located in areas within the program accessible to youth. There is a locked drop box provided in these areas for the completed forms to be placed. The program's youth advocate is responsible for checking these boxes daily. If a youth's issue cannot be resolved at the first, or informal phase, the formal grievance is to be answered by the youth advocate, who has seventy-two hours to respond to the received grievance. If the youth is not in agreement with the solution offered, the third step, or appeal phase, is completed. In this step, the grievance is forwarded to the facility administrator (FA) who will review the grievance and provide a response to the youth within seventy-two hours of receipt. The youth handbook is provided to each youth upon admission, and also contains the grievance completion instructions.

A review of grievances maintained by the program for the past twelve months found only two grievances for the scope of the annual compliance review. The grievances were reviewed and found to be resolved at the formal phase, and within the required timeframe. The program also maintains copies of completed Speak Out forms in a binder. A review of the documentation found only one completed form for the scope of the annual compliance review. The FA was interviewed and was able to summarize the grievance process. Seven staff were interviewed concerning the grievance process. The staff responded stating forms are placed throughout the program and youth are able to request assistance in completing a grievance. Overall, staff were able to identify the process and phases associated with it. Seven youth were interviewed concerning the grievance process. Five of seven reported they have not completed a grievance. One of the seven youth reported he was not familiar with the process. When asked if youth can

ask for assistance when completing a grievance form, five of the seven interviewed youth confirmed they can, and the remaining two youth stated they could not.

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

A review of the provider's contractual agreement found the curriculum Thinking for a Change (T4C) to be the program's delinquency intervention. The T4C curriculum is evidenced-based. A review of the program's activity and therapeutic group schedule determined the program is providing structured, planned programming activities at least sixty-percent of the youth's awake hours. A review of group sign-in sheets confirmed youth participation and groups were being delivered as indicated on the program's group schedule. Five staff are responsible for facilitating the curriculum. A review of each of the five staff training and personnel records found each had evidence of training for facilitation of the T4C curriculum. Staff had the appropriate level of education and number of years required for working with juvenile offenders. A review of the provider's contractual agreement also listed the following required services: Young Men's Work, Teen Relationship Workbook, Anger Management, and Life Skills. An interview with the clinical director revealed all youth receive these services. Samples of group sign-in sheets were reviewed to determine groups were being conducted as required. The facility administrator was interviewed and stated all the program's life skills training is provided by academic degree-level staff, to include case managers, therapists, and the recreation therapist. A review of staff's education and background is conducted to ensure they meet all requirements. Staff who hold special certifications are held accountable for any recertifications needed to maintain their certification status. Seven youth records were reviewed for inclusion of delinquency interventions within their performance and treatment plans. All seven youth records contained evidence the youth were, or had been, involved in a delinquency intervention which was evidenced based. Five of the seven youth were currently participating in T4C. One youth completed the curriculum in December of 2019, and the other youth had completed the curriculum in 2018, prior to admission into this program. However, this youth is scheduled to participate again in the curriculum at the next available group. All youth records included evidence the youth were involved in the delinquency intervention addressing an identified priority need.

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

The program provides life and social skills training and intervention services addressing communication skills, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking skills training. A review of the program's policy, and group schedule revealed therapeutic services are held weekdays from 2:15 p.m. to 4:15 p.m. Weekend groups are conducted at 10:00 a.m. and 12:30 p.m. Therapists rotate working weekends to help facilitate the groups. The program employs a total of four therapists. There

was one vacant therapeutic position, according to the program. A review of the provider's contractual agreement listed the following required services: Young Men's Work, Teen Relationship Workbook, Thinking for a Change (T4C), Anger Management, and Life Skills. An interview with the clinical director revealed all youth receive these services. Samples of group sign-in sheets were reviewed to determine groups were being conducted as required. The clinical director reported they have a transitional specialist who completes assessments with each youth to give job skills and discuss various life skills. The clinical director reported community service activities are facilitated by the recreational therapist. The recreational therapist facilitates life skills activities such as culinary projects, vision boards, and developing long and short-term goals with youth. Seven interviewed youth reported they are participating in groups at the program. The youth stated they participate in groups such as T4C, substance abuse, anger management, pro-social thinking, and coping skills. Seven youth were asked to describe any new skills or behaviors they have acquired in these groups. Four youth were able to express things they have learned in groups and three were not. When asked if they have practiced skills they have learned in groups, four reported they have and were able to discuss ways they have practiced the skills learned, and three were unable to express skills learned.

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 the delivery of restorative justice awareness. Each of the seven had evidence of receiving services to help youth increase awareness and empathy for crime victims and survivors, as well as accountability for criminal actions and harm to others. According to the program's contract, the program provides community service activities designed to restore community competency by instructing youth on accepting responsibility, empathy, restoring victims, and increase community belonging. Youth participate in community service projects which allow them to understand and accept responsibility for the harm they have caused and challenges them to modify their irresponsible thinking. Youth are given the opportunity to give back by participating in neighborhood clean ups, feeding the homeless, and engaging in other local community events which gives the youth access to speak with community members who can speak with the youth providing a victim's perspective. These activities teach the youth about the impact of crime on their victims, families, and communities. Youth are given follow up activities to help them process their reactions to victim statements and how crime has affected their lives. The recreational therapist is the person responsible for scheduling and maintaining restorative justice projects for the program. The recreational therapist has a calendar with planned restorative justice projects and activities. Documentation of these projects is maintained by the recreational therapist in a binder which includes sign-in sheets, pictures from activities, and the calendar of events. An interview with the facility administrator was conducted. She was asked to explain what types of restorative justice groups/activities are provided to the youth. She responded the program's recreational therapist and transition service managers utilize on campus groups and activities, as well as a variety of community service programs, both on and off campus, to expose youth to restorative justice practices. Youth have participated in community clean up events. The youth sample reviewed found evidence they were receiving services to increase the accountability for criminal actions and harm to others.

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

Based on a review of the provider's contractual agreement, the program is required to provide the curriculum Male Healthy Relationships and Young Men's Work for gender-specific programming. The program's activity schedules are inclusive of the groups and gender-specific programming. The program designs the services based on the common characteristics of the male population served. A review of group agendas and sign-in sheets was completed to confirm the groups are held regularly as scheduled. According to the clinical director, all groups are facilitated by master's-level therapists. The facility administrator was interviewed and stated the program provides targeted health education, male medical exams, group curriculum, daily groups with specialized topics, and a Male Healthy Relationships bundle, which includes the Young Men's Work curriculum. In addition, recent discussions of the lesbian, gay, bisexual, transgender, questioning, intersex (LGBGTQI) specific groups have been completed 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 policy and procedures to address internal and Department of Juvenile Justice Information System (JJIS) alerts, which determines how alerts are identified, documented, updated, and communicated to staff. The program maintains an internal alert system for all security, medical, and dietary alerts. Internal security alert information, as well as identification of youth on Precautionary Observation status is captured in logs at the beginning of each shift. A sample of log entries was reviewed to confirm the program's practice. A master alert board is posted in the staff meeting room which displays internal alerts for youth. Staff discuss alerts during shift briefings which are held in this location. Youth with dietary concerns, food allergies, and restrictions are posted on an internal alert board located in the kitchen area for dietary staff to view. JJIS alerts are reflected in the internal alert system. The facility administrator was interviewed, and stated alerts are reviewed and discussed during each morning meeting. The mental health, medical, operational, and clinical staff have access to enter and close out alerts in JJIS. All department heads receive internal alert sheets. Seven youth were selected to review for the Department's JJIS and internal alert information. A total of twenty-two alerts were reviewed for these seven youth. All alerts were entered by the required staff member. All were verified prior to entering into the Department's JJIS. All applicable alerts were documented in the program's logbook. A review of youth case management, medical, mental health, and safety and security alerts verified those youth reviewed were placed on the

alert system as specified within the program's written procedure. Seven staff were interviewed concerning the program's alert notification process. Each staff stated they are notified of youth alerts through the alert board located in the breakroom and at shift briefings.

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

The program separates youth records into two separate files: an individual healthcare record and an individual management record. A review of five individual management records found they were all organized as required, containing a file tab which included the name of the youth, Department's identification number, date of birth, county of residence, and committing offense. Sections were divided to include legal information, chronological information, correspondence, case management and treatment team activities, and a miscellaneous section. All records were labeled confidential and were secured behind two locks within the case managers' office. The program identifies doors used to store these records as confidential.

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

The program has a formal process in place to promote constructive input by youth. Speak Out forms are available in program areas and are used for youth to complete in the event they have issues or concerns. Grievances are also made available within these locations. The program has a locked drop box provided for youth to deposit completed forms. The box is checked daily by the youth advocate. Samples of completed Speak Out and Grievance forms were observed. Documentation was obtained of dorm house meetings, along with signatures from youth. These meetings are conducted monthly. The youth advisory board meets monthly and is facilitated by the youth advocate. A review of agenda topics for these meetings include discussions regarding program and youth concerns, youth leadership, new ideas or incentives, menu planning, youth outings, and open floor discussion. Documentation confirms meetings were conducted each month of the scope of the annual compliance review period. Three documented meetings were completed for the month of December. The program administration reported additional meetings were conducted at that time due to problematic behaviors youth were exhibiting during month of December. In addition, quarterly youth surveys are completed randomly and administered by the provider's compliance manager. The surveys are conducted through an electronic survey program, and results are sent to corporate office for review, then relayed to the program staff during staff meetings. Seven youth were interviewed to determine if they were able to provide input into the program operations. Three youth were unsure about process for input. Two youth stated they are able to choose incentives and activities. Two youth were familiar with the youth advisory board but did not participate in it. The facility administrator was interviewed concerning youth input and stated the program utilizes dorm meetings, youth advisory boards, treatment team meetings, and the community advisory board to solicit input from youth about the program. In addition, the program uses Speak Out forms and youth surveys.

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

The program holds community advisory board meetings quarterly as evident of agendas, sign-in sheets, and meeting minutes reviewed. The program held a meeting in June, September, and December of 2019. The program solicits advisory board participation from the following members: a representative from law enforcement, the judiciary, community partners, business community, faith community, victim advocate, and a parent/guardian whose child was previously involved in the juvenile justice system. Documentation of a representative from the school board or district was not clearly identified based on information observed. A telephone interview with a randomly selected advisory board member was completed to confirm their participation. The member confirmed her participation on the advisory committee, and stated she meets as scheduled and is notified through email. She stated she has enjoyed her participation with the program and they meet to discuss ways to assist youth in the program. The facility administrator (FA) was interviewed concerning the advisory board and stated the community advisory board is comprised of various individuals who meet quarterly and give program updates, solicit feedback, and invite youth to participate so they can also give feedback or express any concerns or needs. The community advisory board is an advocate for the program's needs and improvements. The FA further stated an example of implementing improvements from the board is using their support to furnish the clothing closet for youth who may get released from the program with no regular clothing to wear, or those who may need proper attire to dress for job interviews. Board members have also been instrumental in providing resources and materials which are needed to the youth during placement, such as books, vocational materials, 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 policy and procedures which discusses the dissemination of information to staff at the program. The program conducts parent/guardian surveys at each visitation held. In addition, parent/guardian surveys are administered at each youth admission and release. Samples of these surveys were observed to document the program's practice. The program displays the Comprehensive Accountability Report (CAR) in the administration area of the program. Survey results, and results of the CAR are incorporated into the program planning process. The provider's corporate office sends the CAR report annually, and information form the report is discussed with program staff during staff meetings. The facility administrator (FA) and human resources officer were interviewed and stated the program provides a referral bonus plan, which gives monetary rewards for staff referrals of new hires. Copies of the plan were observed. In addition, the program provides Catch People Doing Right Cards, which are given out to staff who perform job duties well. The cards are given to staff, who then give them to the human resources manager, and their names are placed in a raffle for the opportunity to win tangible or monetary prizes. Quarterly staff surveys are also completed and administered by the provider's compliance manager. Samples of surveys were reviewed to confirm the practice. The FA indicated staff meetings are held regularly. The program conducts morning management meetings, which are conducted daily and are facilitated by the FA. All staff meetings are completed monthly and are facilitated by the FA. Shift Briefings are completed at each shift change and are facilitated by the shift supervisor. Samples of these meeting minutes, sign-in

sheets, and agendas were observed to confirm the program's practice. Seven interviewed staff confirmed meetings are held at the program. The staff interviewed stated topics which were discussed include program issues, alert information, breaks, staff positioning, ten-minute observation checks, staffing issues, and policy information. When asked if staff were briefed on annual reports as well as youth or parent/guardian surveys, two staff reported no, and five staff reported yes. Seven staff were asked how well communication at the program was. Two stated it was good, three stated it was fair, one stated it was poor, and one stated very poor. Two staff expressed their ability to provide input and feedback into program operations for improvements. The FA reported the program currently has ten direct care vacancies. She further reported, in December 2018, the program was placed on a freeze due to staffing shortage and was cleared from the verification process in May 2019. However, since then the program has consistently hired and conducted new hire classes to fill vacancies. The next new hire class is scheduled to start February 2020.

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

The program has a written policy and procedures addressing staff performance and the administering of formal evaluations. The procedure indicates all staff receive an evaluation after the initial ninety-days from their hire date, and then annually thereafter. A sample of three performance evaluations were reviewed for the positions of therapist, youth care worker, and transition case manager. All three personnel records included evidence the evaluations were completed as required. Job descriptions for these positions were also reviewed and ensured each staff member's performance standards were clearly identified. The performance standards matched job descriptions for each staff. A review of key positions outlined with the provider's contract revealed all key positions were currently being maintained in the program. An interview with the facility administrator revealed all staff are provided evaluations. Five staff were interviewed and all indicated they have received evaluations while employed at the program.

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

The program has a written policy and procedures which include the provision of activities based on the development levels and needs of the youth. A review of the program's activity schedule includes activities such as visitation, education activities, recreation, and therapeutic activities. The program's activity schedule documents a range of supervised and structured indoor, outdoor recreation, and leisure activities for youth. The program's logbook was reviewed to show activities are documented according the schedule. An interview with the program's administration revealed the youth have held some recreation activities inside due to current repairs on the perimeter fence. Precautionary measures to prevent over-exertion were also captured within the program's policy. The recreation therapist was interviewed, and stated youth are given lists of activities to choose from for the upcoming month, thus giving them the opportunity to help create the recreation calendar. Youth are given choices for leisure and recreation options. The recreational therapist stated youth have participated in off campus activities as well, such as tours of local colleges. The recreation therapist creates a wellness plan for each youth once admitted and the youth assists in creating the plan. The recreation goals are then created based on the wellness plan. This is completed within the youth's first fourteen days of admission. Samples of the plans were observed to demonstrate the program's

practice. Recreation and incentive calendars are posted within each youth living area. Observations of the program's logbook confirms the program documents heat stress and temperature levels as well as environmental hazards at the beginning of each day. A sample of three youth treatment plans were reviewed and found incorporation of recreational activities and goals, as well as responsibilities for the recreational therapist. The program has a formal process in place to promote constructive input by youth. Speak Out forms are available in program areas and are used for youth to complete in the event they have an issue or concerns. Grievances are also made available within these locations. The program has a locked drop box provided for youth to deposit completed forms. The box is checked daily by the youth advocate. Samples of completed Speak Out forms and Grievance were observed. Documentation was obtained of Dorm House Meetings, along with signatures from youth. These meetings are held monthly. The Youth Advisory Board meets monthly and is facilitated by the youth advocate. Agenda topics for documentation observed included topics such as program and youth concerns, youth leadership, new ideas or incentives, menu planning, youth outings, and open floor discussion. Meetings were observed documented for each month of the scope of the annual compliance review period. Five of seven interviewed youth reported physical activities were provided for one hour. Two of seven reported they were not. Five of seven interviewed youth confirmed they were provided with varying degrees of mental and physical exertion throughout the day. Two stated they were not. Seven interviewed staff reported youth are provided with activities such as football, basketball, track, board games, art activities, and music.

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.	

Seven youth case management records were reviewed for initial contact to parent/guardian and court notification. In each record there was evidence the program notified the parent/guardian by telephone within twenty-four hours of the youth's admission. All seven youth records had documentation the parent/guardian was notified in writing within forty-eight hours of admission; including notification to the committing court and juvenile probation officer (JPO) within five working days of admission.

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

Seven youth case management records were reviewed for youth orientation. In all seven records, the youth were provided an orientation upon admission. Orientation included the following: services available, a daily schedule, expectations and responsibilities, written behavioral management system, access to medical and mental health services, access to the Florida Abuse Hotline and the Central Communications Center (CCC) for youth over the age of eighteen, items considered contraband, performance planning process, dress code and hygiene practices, procedures on visitation, mail and use of the telephone, anticipated length of stay, community access, physical design of the program and assignment to a living unit and room and treatment team. The program did not have a youth admission to be observed during the annual compliance review. The program logbook showed youth orientation takes place during admission. The orientation process included all elements of the program's policy. Seven interviewed youth all confirmed the orientation process began within twenty-four hours of their admission to the program. Each of the youth were able to summarize the orientation process.

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

Three of seven case management records were applicable and reviewed for written consent of youth eighteen years of age or older. Written consent was obtained for all three youth before discussing or providing information to the parent/guardian relating to physical or mental health screening and treatment. None of the three applicable youth were being served by the Agency for Persons with Disabilities.

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

The program has a written policy and procedures which outlines the classification process. The program's classification system promotes safety and security with an effective delivery of treatment services. Seven youth case management records were reviewed for classification factors and procedures. Six of seven case management records reviewed considered the following: physical characteristics, age, maturity level, any special needs, history of violence, gang affiliation, criminal behavior and sexual aggression or vulnerability. Identified and suspected risk factors included suicide risk, medical risk, escape risk and security risk. The Department's Juvenile Justice Information System was checked for any issues affecting classification and for purposes of the youths' living area assignment. For the remaining record, classification documentation was completed on a Reclassification form and not the correct form. Reassessments were completed prior to considering an increase in the youth's privileges, participation in work projects or other activities involving tools and participation in off-campus activities. Four of seven records found evidence the youth were not approved for privileges including participation in work projects, off-campus activities, or activities involving tools. The facility administrator was interviewed and stated factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning youth to a living unit and room. These factors are examined and taken into consideration during the pre-classification process, and they also help with setting goals for the youth. The program has a continually updated internal alert system which is easily accessible and visible for staff to be informed on youth who have been determined a security, safety, medical, or mental health risk.

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 of seven youth case management records reviewed were applicable for review of gang identification and notification to law enforcement. In each of the applicable records, local law enforcement was notified for suspected gang activity or involvement. Law enforcement in the youth's home counties were notified in all three cases. Gang alerts were added for newly admitted youth into the Department's Juvenile Justice Information System (JJIS). The youth's gang status was shared with the local school district and with the youth's juvenile probation officer. The post residential counselor was not applicable in all three 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.	

A review of seven case management records found three youth had been identified as a gang member or affiliated gang member. All three youth participate in gang prevention activities and each youth's performance plan includes goals and objectives relating to gang intervention strategies to be completed before release from program. The program utilizes life and social skills training as well as restorative justice projects. The program has a written policy and procedures ensuring youth have the opportunity to develop a plan to dis-affiliate with a criminal street gang.

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

Seven youth case management records were reviewed for completion requirements of the Residential Assessment for Youth (RAY) Assessments and Reassessments. Six of seven records included documentation of the RAY being completed within thirty-days of the youth's admission. One youth's RAY had not been completed at the time of the annual compliance review. This youth was a transfer from another program in September 2019, and the program reported the completed RAY on file from the sending program was used to capture youth goals and risk factors. Initial RAY Assessments for the youth were maintained in the Department's Juvenile Justice Information System (JJIS). RAY Re-assessments were applicable for five of the seven youth records reviewed. RAY Re-Assessments were discovered in four of the five youth records, as the one youth who was a transfer from another program did not have a ninety-day Reassessment as required. All RAY Reassessment documentation was maintained in each youths' applicable record.

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

Seven youth case management records were reviewed for the Youth Needs Assessment Summary (YNAS). In six of seven records, the YNAS was completed within thirty days of admission and the YNAS was documented in the Department's Juvenile Justice Information System. In the remaining record, the youth was a transfer from another program; however, a new YNAS was not updated for this youth.

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.*	

Seven case management records were reviewed for performance plan development, goals, and transmittal of the performance plan to the appropriate parties. Five of the records were developed and completed within thirty days of youth admission. One plan was thirty-five days late and one was not completed, as this youth was a transfer from another program. In the remaining six cases, the individualized performance plan was developed after the initial assessment. In these records, there was evidence the following treatment team members were present: Treatment leader, youth, administrative representative, living unit representative, and treatment staff. The educational staff was able to provide input for youth. One youth was represented by the Department of Children and Families. Performance plans were signed by the youth, the treatment team leader and all parties whom had a significant responsibility in goal completion. In all applicable records, the parent/guardian signature sheet was returned to the program, attached to the original performance plan, and filed in the youth's record. The case management records had performance plans which contained all the required elements. Each record had individualized goals based upon the risk and protective factors from the initial assessment and the top three criminogenic needs were addressed. There were measurable outcomes to decrease risk factors and to promote strengths which reduces the youth's chance of reoffending. All plans targeted court ordered sanctions which could be started or completed in the program. Six of the seven records had transition activities targeted for the last sixty days of stay, youth and program staff responsibilities to complete goals and target dates for completion. The transmittal letter and the plan were sent to the committing court, juvenile probation officer, and the parent/guardian. In one case the transmittal letter and the performance plan were sent to the Department of Children and Families case manager. Seven youth were interviewed. All youth reported they have a copy of their performance plan. Six of seven youth were able to briefly summarize their goals and the treatment team and treatment planning process. One youth stated he is unsure about the process, but indicated his goals were ongoing.

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 case management records were reviewed for performance plan revisions. Three records were applicable and included revisions made to the performance plan due to the result of Residential Assessment of Youth (RAY) Reassessment competed. In one of the original seven records reviewed, the youth was a transfer from another program, and the current program did not complete a RAY Reassessment for this youth revising requirement timeframes for

completion of goals documented in the plan. For the remaining three applicable records, revisions were completed based on the youths' demonstrated progress, or lack of progress towards goal completion. In all four applicable records, revisions were made to facilitate transition activities during the last sixty days of the youth's stay.

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

Seven case management records were reviewed for the reassessment being completed every ninety days following the signing of performance plan. Four of the seven were found applicable for requiring performance summaries and transmittals. One of four performance summaries was late. The summary was due December 6, 2019 but was completed January 22, 2020. Each of the four performance summaries included youth status on each performance plan goal, overall treatment progress, academic status, youth's behavior, level of motivation and readiness to change, interaction with peers and staff, significant positive and negative events, and justification for release. Original summaries are filed in the youth case management record. For one of the performance summaries reviewed, the youth did not sign the summary or include any comments in the comment section. There was evidence youth were provided a copy of their summary in three of the four records reviewed. Three of the four summaries included signatures from the treatment team and staff preparing the summary. In three of four records reviewed, a copy of the summary was sent to the committing court, the juvenile probation officer (JPO), youth, and parent/guardian within ten working days. None of the four youth were applicable for submittal of the summary to a Department of Children and Families (DCF) representative. Three records were applicable for requiring a release summary. One of the three was not signed as required. In the remaining two, the original summaries, along with the justification for release, was sent with the pre-release notification to the JPO as required. All three applicable release summaries were sent within three weeks of the annual compliance review; therefore, no approval from the committing court had been obtained at the time of the review. None of the youth were applicable for sexually violent predator notification requirements. Two were applicable for victim notification, however both records indicated the victim notification was waived.

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 solicits involvement in the youth's case management process with the parent/guardian. The parent/guardian is able to participate in person or by phone in the following: assessment process, development of youth's performance plan, progress reviews and formal treatment teams. The parent/guardian has advanced notice of meeting times and dates and can participate by phone or give written input. There were no treatment team meetings to

observe during the annual compliance review. The program sends letters and makes phone calls to try to encourage parent/guardian involvement. The facility administrator was interviewed, and stated parents/guardians are called during pre-classification and given an overview of the program and introduced to their youth's therapist and case manager. The parent/guardian receives a formal letter in the mail reiterating information which is shared during pre-classification. Parents/guardians are encouraged to participate in treatment teams, weekly phone calls, writing letters, family days, and family therapy. Six of seven interviewed youth stated their parents/guardians are involved in the case management and treatment process. One youth stated he is nineteen and does not require his parent/guardian participation.

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

The program's treatment team members consist of the following: Treatment team leader, youth, administration representative, living unit representative, treatment staff, educational staff, Department of Children and Families caseworker if applicable, juvenile probation officer (JPO), parent/guardian and the program's gang prevention specialist if applicable. A review of the provider's contract determined others required for participation in the treatment team process such as a nurse, recreational therapist and transitional specialist. Seven youth case management records found evidence all required parties participate in treatment team meetings.

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

Five of the seven case management records reviewed were applicable and included an academic and wellness plan referenced in the performance plan. All five applicable records included a separate mental health or substance abuse issue which was incorporated into the performance plan. One of the records reviewed was applicable for requiring a current behavior plan through the Department of Children and Families (DCF) incorporated into the performance plan. This youth's case management record included a current behavior support plan with DCF.

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

Seven youth case management records were reviewed for formal and informal treatment team meeting requirements. In all seven, formal reviews were held at least every thirty-days. Formal treatment team documentation included the youth's name, date, comments from treatment team members, a synopsis of the youth's progress in the program, any performance plan revisions, positive and negative behaviors, progress with goals, and treatment progress. Youth were provided the opportunity to demonstrate skills acquired in the program. One of five applicable records did not include results of a Residential Assessment for Youth (RAY). Informal treatment

team meetings are held at the program. For the seven records reviewed, all had evidence the informal meetings were taking place as scheduled. Informal review documentation included all required elements. One of seven youth records did not include a performance plan revision as required. A treatment team meeting was unable to be observed during the annual compliance review. Seven interviewed youth all confirmed staff review their performance to include any progress on performance plan goals, positive and negative behaviors, and treatment progress. Six of seven youth reported they are given an opportunity during treatment team meetings to demonstrate any skills they have learned in the program. One stated they have not learned any skills.

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

The program has a policy and procedures to provide for career education. The program provides Type 2 vocational competency development programming offering career education, which includes the required vocational training, communication, inter-personal, and decision-making skills. An interview with the lead educator indicated SafeStaff vocational course is provided to all youth and a culinary arts course is available for youth who are interested in the certification. The courses are all age appropriate and aligned with the youth's educational goals and abilities. Three closed youth case management records were reviewed. All three records included a résumé, completed sample job applications, and documentation confirming information had been given to the youth about their local Career Source office. The facility administrator was interviewed concerning what career or vocation services are offered to youth. The facility administrator reported youth are offered services for food management, food handling, Home Builder Institute (HBI), Career Source résumé writing, Florida Ready to Work certification, cardiopulmonary resuscitation, and first aid.

2.17 Educational Access	**Limited 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 has a written policy and procedures to provide for educational access. The program integrates education into the daily schedule in such a way to ensure the integrity of required minimum instruction distributed over 250 days. The district and site calendars were reviewed and incorporated the 250 days which also provided for the minimum of twenty-five hours of instruction a week. The daily schedule consists of seven fifty-minute class periods from the hours of 7:15 a.m. to 2:15 p.m., with all youth enrolled in an academic schedule and receiving credit for their courses. An interview with the lead educator indicated the school schedule is adhered to with periodic deviations at times, especially at the beginning of the school day. Seven youth interviews were reviewed with five of the youth indicting there were interruptions to the school schedule. A review of the logbook, several weeks and random days in September, November, and December 2019, confirmed the school schedule is not being adhered to and the youth are not being taken to class on time. There was no pattern noted, but on all days reviewed the youth were at least fifteen minutes late for the first period class, and several days an hour or more. Although the times were sporadic, there is enough documented evidence to indicate the integrity of the required instructional time is being affected.

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

The program has a written policy and procedures to provide for an educational transition plan. Three closed youth records were reviewed and confirm the program's instructional staff and youth completed an education transition plan upon entry, which included services and interventions based on each student's assessed educational needs and post release education plans. All three youth records contained the documents essential to employment such as a Florida identification card, résumé, and sample job applications. Each of the three records contained an exit conference form indicating the case manager, parent/guardian, and youth were all 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.*	

One open and three closed youth records were reviewed for completion requirements concerning transition planning, conference, and Community Re-Entry Team (CRT) meetings. In all records reviewed, the transition conference was held at least sixty-days prior to the targeted release date. Documentation revealed all required treatment team members attended the conference in all four records reviewed. Invitations for participation were sent to all required parties, to include the youth's juvenile probation officer (JPO), parent/guardian, education staff, and any other pertinent parties. During the conference, participants review transition activities, make plan revisions, identify target completion dates, and activities needed, as well as identify persons responsible for completion of tasks. Signatures were obtained on documentation as required. Copies of each plan were sent with a request for return with signature to anyone not in attendance who has a responsibility for transition goal completion. For all four records reviewed, a CRT meeting was conducted as required. Both the youth and case manager were participating the meeting.

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

Three case management records were reviewed for exit portfolio requirements. In all three records, the exit portfolio was discussed and initiated for the youth at the transition conference. All records had a state issued identification card and a calendar for follow-up appointments once the youth is released. All records included copies of the youths' transition plan. The following items were in the exit portfolio for all three records: social security card, birth certificate, vocational certificates earned in the program, and educational records. All three records had the school transcripts included. All three had a completed résumé and sample job application. All three records had documentation indicating the education staff forwarded the portfolio information to the receiving school district. The youth's exit portfolios were verified at the exit conference and the youth were given a copy upon release in all three records. The exit portfolios were sent to the assigned juvenile probation officer in each of the three records.

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 exit conference documentation. In each of the three records reviewed the conference was conducted at least fourteen days prior to the youth's release and the juvenile probation officer was notified of the youths' release. All were documented in the case management record to include the date and signatures, names if by telephone, and summary of pending transition goals. Each had the date of admission and the date of termination documented. These dates correlated with the dates located in the Department's Juvenile Justice Information System (JJIS). All three included a review of transition activities established at the transition conference. In all three of these records reviewed, the treatment team leader was involved in the exit conference process. All required parties were documented to have participated in each of the exit conferences.

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 psychologist licensed under Chapter 490, Florida Statues, who serves as the designated mental health clinician authority (DMHCA). A review of the psychologist licensure was conducted, which revealed the license is clear and active, and expires May 31, 2020. The DMHCA is a full-time employee of Gulf Academy and is on-site forty hours a week which is a sufficient amount of time to ensure appropriate coordination and implementation of mental health and substance abuse treatment services. A copy of the DMHCA's licensure and position description were available for review while on-site. Gulf Academy provides specialized treatment services to include intensive mental health services. An interview was conducted with the DMHCA to determine his role in the coordination and implementation of mental health and substance abuse services at the program. The DMHCA provides supervision of all therapists at the program. Supervision is focused on the delivery of therapeutic services and the preparation of required program documentation, including comprehensive evaluations, treatment plans, discharge summaries, and weekly progress notes. The DMHCA provides weekly supervision of therapists focused on problematic cases and development of recommendations on behalf of those youth. The DMHCA provides training of therapists in providing suicide and crisis evaluations. The DMHCA consults with other program departments and participates in daily management meetings. In addition, as a psychologist, the DMHCA conducts psychological evaluations of referred youth to address intelligent quotient levels, diagnostic and treatment issues, and recommendations. The evaluations include psycho-educational and personality/psychopathology instruments, and on an as needed or requested basis, the DMHCA conducts individual, group, and family therapy sessions. The DMHCA also initiates and signs involuntary professional Baker Act certificates. The DMHCA participates in weekly clinical supervision meetings with the program therapists. The DMHCA meets on a daily and weekly basis with therapists relative to review of preparation of required documentation and delivery of required therapeutic services. The DMHCA is available throughout the course of the week for the purpose of consultation. The DMHCA meets with the psychiatrist at least once or twice a week, sometimes more, as needed. The DMHCA participates in weekly psychiatric meetings in which youth who are going to be seen by the psychiatrist for the week are discussed. The focus of the meetings includes issues of diagnoses, medications, and treatment recommendations.

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 designated mental health clinician authority assures the licensed clinical staff working under his supervision are performing service they are qualified to provide, based upon education, training, and experience. The program employs the following licensed positions: two psychiatrists and one licensed mental health counselor (LMHC), who provides mental health and substance abuse treatment services. The program's mental health and substance abuse staffing is in accordance with the program's contract and Florida Administrative Code, 63N-1. A review of the two psychiatrists and one LMHC licensures, revealed each were clear and active. The program does not require juvenile sexual offender therapy services according to Florida Administrative Code 64B19-18.0025.

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 designated mental health clinician authority assures each of the five non-licensed clinical staff are performing services each of them are qualified to provide based on education, training, and experience. All five non-licensed clinical staff hold the appropriate level of education necessary and are in accordance with the contract between the provider, the Department, and Florida Administrative Code 63N-1. The clinical supervisor conducts weekly on-site, face-to-face interaction with each of the five non-licensed clinical staff; which are at least one hour in duration, for each contact. Documentation of direct supervision is recorded on a similar form to the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log; which included all necessary information. The five reviewed non-licensed clinical staff hold a master's-level degree from an accredited university in either the field of counseling, social work, psychology, or another related human services field. Each of the five non-licensed clinical staff and are following Florida Administrative Code 63N-1 and current contract. The five non-licensed substance abuse clinical staff may provide substance abuse services in the program, as the program is licensed under Chapter 397, Florida Statutes, to provide substance abuse treatment services; certified by the Department of Children and Families (DCF), which is effective April 8, 2019 and expires April 7, 2020. In addition, each non-licensed substance abuse clinical staff hold a master's-level degree from an accredited university in either the field of counseling, social work, psychology, or another related human services field. All five non-licensed clinical staff have received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The non-licensed clinical staff's training is documented on the Department's Non-licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk (ASR) form. Each non-licensed mental health clinical staff work under the direct supervision of a licensed mental health professional. The licensed mental health professional provides a minimum of one hour a week of on-site, face-to-face direct supervision to each of the five non-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.	

Seven youth records were reviewed for a mental health and substance abuse admission screening. Each of the youth reviewed, had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) administered upon admission to the program. Each of the MAYSI-2 screenings administered were completed by trained staff. All available information was reviewed, to include the commitment packet, reports, and records from existing documentation of mental health and or substance abuse issues. Each of the seven MAYSI-2 screenings were completed on date of the youth's admission to the program in a confidential manner. The MAYSI-2 screenings were administered in the Department's Juvenile Justice Information System (JJIS). All of the MAYSI-2 screenings reviewed were completed in full. Two out of the seven youth reviewed indicated further assessment was required. Each of the youth were referred for further evaluation. In each of the seven youth records reviewed, regardless of the MAYSI-2 findings, a referral was made based on the youth having either a mental health need, substance abuse problem, or was a suicide risk. In each of the seven youth records, a referral for further evaluation was generated. Pursuant to the program's written facility operating procedures, all youth admitted into the program are administered an Assessment of Suicide Risk (ASR) on the day of admission. All youth admitted into the program are screened using the ASR on the day of admission and provided with a comprehensive evaluation within thirty days of admission. The seven ASR's were administered within twenty-four hours of the staff referral. In each of the seven-youth referred, a reason for referral was documented. The program director has developed written facility operating procedures (FOP), addressing the implementation of a standardized admission and intake mental health and substance abuse screening process. The written FOPs include the following elements: standardized screening process which includes review of commitment packet information, reports and records; administration of the MAYSI-2 on the Department's Juvenile Justice Information System (JJIS) or Clinical Mental Health Screening by a licensed mental health professional and Clinical Substance Abuse Screening by a "qualified professional" and referral of juvenile offenders identified by screenings as in need of further evaluation or immediate attention. Each screening administered is conducted by a qualified professional, and a referral made for youth identified in need of further evaluation or immediate attention when necessary. The written FOP also identified staff training in mental health and substance abuse issues and administration of the MAYSI-2. Also, the program's written FOP, identified standardized process for referral of youth identified as in need of further mental health and/or substance abuse evaluation to an appropriate service professional, a hospital, or to a Baker Act or Marchman Act receiving facility when immediate attention is needed. A review of seven youth records verified the program staff were conducting screening, reviewed youth's commitment packet information, reports, and records for existing documentation of all mental health and/or substance abuse problems, needs, or risk factors.

An interview with the program director was conducted. The program director was asked to explain the screening process to identify youth at risk for mental health and substance abuse problems and suicide. The program director confirms the program utilizes the MAYSI-2 at admission. In addition, all youth at admission are provided an ASR. During the admission process, within the first thirty days of admission, a Comprehensive Biopsychosocial Mental Health and Substance Abuse Evaluation is completed by the therapists and signed off by the

licensed mental health professional. All youth are screened by the program's psychiatrist in an initial psychiatric evaluation. The program director explained all of the aforementioned processes are used to screen youth and all of the above can be completed to rescreen the youth.

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 records were reviewed for a mental health and substance abuse assessment and evaluation. Six of the seven youth records reviewed were applicable for completion of a new mental health evaluation. Each of the six evaluations were completed within thirty calendar days of admission. The seventh record was applicable for completion of an updated mental health evaluation, which was conducted within thirty days of admission. All seven mental health evaluations were completed by a non-licensed mental health clinical staff person. Each of the evaluations, were subsequently reviewed and signed within ten days by a licensed mental health professional. The six of seven applicable new mental health evaluations conducted, contained demographics, reason for evaluation, relevant background information, behavioral observations, mental status examination, discussion of findings, diagnostic impression, and recommendations for each youth. The one applicable updated evaluation was clearly identified as such and attached to the previous comprehensive evaluation, which was being updated. The updated evaluation contained all required information, addressing any problems identified at screening, which included findings and recommendations.

Seven youth records reviewed for completion of a substance abuse assessment found six were applicable for completion of a new substance abuse assessment and were completed as required. One youth record was applicable for completion of an updated substance abuse assessment. Each of the seven assessments were completed within thirty calendar days of admission. All substance abuse assessments were completed under the program's Chapter 397, Florida Statutes licensure and contained a signed consent for substance abuse services, from the youth. Each of the substance abuse assessments contained a reason for assessment, relevant background information, behavioral observation, methods of assessment, patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, risk factors of continued alcohol and other drug abuse, clinical impression to include diagnoses from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), and recommendations. Each of the substance abuse assessments conducted address the youth's original referral reason.

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 records were reviewed for mental health and substance abuse treatment. Each youth record reviewed indicates the youth were assigned to a treatment team upon arrival to the program. The multidisciplinary treatment team were comprised of the youth, program administration, staff from the residential living unit, and other staff responsible for delinquency intervention and treatment services for the youth. For each of the seven records reviewed, treatment team documentation validates it is comprised of representatives from administration, education, vocational training, medical staff, mental health staff, substance abuse staff, youth, and when possible the youth's parent/guardian. All seven-youth reviewed were determined to need mental health treatment. Five applicable youth out of seven receiving mental health treatment had a properly executed Authority for Evaluation and Treatment (AET) form on file; the remaining two youth were eighteen years of age or older. Each youth in receipt of mental health services had documentation of a clinical impression to include diagnose from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) mental disorder.

All seven-youth reviewed were determined to need substance abuse treatment. Each of the seven youth had a signed Youth Consent for Substance Abuse Treatment forms and Youth Consent for Release of Substance Abuse Treatment Records forms on file. Each youth in receipt of substance abuse services had documentation of a clinical impression to include diagnose from the DSM-V mental disorder. Mental health treatment and or substance abuse treatment notes were documented on the provider's form, which contained all the required information within the Department's Counseling/Therapy Progress Note form. A review of youth sign-in sheets for mental health treatment groups, documented the groups were limited to ten or fewer youth. Group counseling topics and curriculum utilized for treatment services consist of Strategies for Anger Management, Thinking, Feeling, Behaving, Young Men's Work and Teen Relationship Workbook, 100 Interactive Activities, Living in Balance, and Life Skills 225 Workbook. A review of youth sign-in sheets for substance abuse treatment groups, documented the groups were limited to fifteen or fewer youth. Each of the seven youth records contained documentation the youth were involved in individual psychotherapy or counseling. Youth were engaged in therapeutic activities designed specifically to address skill deficits or maladaptive behaviors as outlined within their individual treatment plans. Substance abuse treatment is provided for by a licensed qualified professional or a non-licensed substance abuse clinical staff, who are employees of a service provider under Chapter 397, Florida Statute. The programs licensure is effective April 8, 2019 and expires April 7, 2020.

Interviews were completed with seven youth. Six of seven youth agree they participate in groups and are receiving specialized therapies, which includes substance abuse treatment. Interviews were conducted with seven staff. Each staff was asked, do you or other direct care staff facilitate any mental health or substance abuse groups; all seven-staff replied, no. An interview was conducted with the program's designated mental health clinician authority (DMHCA). The DMHCA was asked, does the program offer any type of specialized services and, if so, how do you ensure these services are delivered in a manner consistent with

contractual requirements. The DMHCA replied; Gulf Academy currently does not offer any specialized clinical/therapeutic services. The DMHCA was also asked what clinical services are provided and indicated he conducts psychological evaluations of referred youth to address intelligence quotient levels, diagnostic and treatment issues, and recommendations. The evaluations include psycho-educational and personality/psychopathology instruments, and on an as needed or requested basis the DMHCA conducts individual, group, and family therapy sessions. The DMHCA also initiates and signs involuntary professional Baker Act evaluation forms.

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 records were reviewed for youth treatment planning. Each of the youth records reviewed, contained an initial mental health and substance abuse treatment plan. The initial mental health and substance abuse treatment plans were site-specific, which included all the information contained within the Department's Initial Mental Health/Substance Abuse Treatment Plan form. All seven youth records reviewed, had an initial mental health and substance abuse treatment plan developed within seven days of admission to the program. Each of the initial treatment plans were completed by a non-licensed mental health clinical staff person, which were later reviewed and signed by the licensed clinical supervisor within ten days of completion. The initial treatment plans were signed by treatment team members who participated in the development of the plan. Three of the seven youth reviewed, were applicable for psychiatric needs upon admission. Each of these youth's initial treatment plans, included his psychiatric needs. The psychiatric needs addressed medication and frequency of monitoring by the psychiatrist.

Seven youth records were reviewed for development of an individualized treatment plan and reviews. Each of the youth records reviewed, contained an individualized treatment plan, which was developed within thirty days of the youth's admission to the program. The seven individualized treatment plans reviewed, were developed on a form which contained all the elements of the Department's Individualized Mental Health Treatment Plan form. The individualized treatment plans were completed by a non-licensed mental health clinical staff person and were subsequently reviewed and signed by the program's licensed supervisor within ten days of completion. All of the individualized treatment plans were signed by treatment team members who participated in development of the plan, along with the youth, and parent/guardian, when available. Six of the seven applicable individualized treatment plans reviewed were applicable for the inclusion of psychiatric services, to include psychotropic medication and frequency monitoring by the psychiatrist. Three youth arrived on psychotropic medications and three youth were later placed on psychotropic medications; each plan was established accordingly. All six applicable youth's individualized treatment plans reflected the required review and monitoring for psychiatric services. A total of twenty-five individualized

treatment plan reviews were conducted, for each of the seven youth records reviewed. Only one out of the twenty-five individualized treatment plan reviews were conducted twelve days late. The remaining twenty-four were completed at a minimum every thirty-days following the development of the individualized treatment plan. Each treatment plan review was conducted and documented on a program specific form which contained all the information in the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form. All seven of the individualized treatment plans documented the on-going prescribed services outlined in the youth's individualized treatment plan; individual, group, family, and/or psychiatric services, as prescribed. A review of each of the youth's individual progress notes, demonstrated youth received services as stipulated on their treatment plan.

Three additional youth records were reviewed for discharge planning. Each of the three discharge plans were documented on the Department's Mental Health/Substance Abuse Treatment Discharge Plan form. None of the three-youth reviewed required any type of notification for suicide alert or precautions. The three mental health and substance treatment discharge summaries documented the services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by youth during treatment. Documentation confirmed each of the three discharge plans had been discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. A copy of the mental health and substance abuse treatment discharge summary were provided to the youth, JPOs, and parents/guardians in each of the three youth records reviewed.

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 is contracted to provide intensive mental health services, substance abuse services, and intensive medical overlay services. The scope of treatment service delivery is outlined within the contract, and applicable amendments, between the provider and the Department. The program treatment service modality as prescribed specifically for each youth may consist of individual counseling once a week for thirty minutes, family counseling once a month for thirty minutes, group counseling seven days a week for one hour, and substance abuse group two times a week (if applicable). Group counseling topics and curriculum utilized for treatment services consist of Strategies for Anger Management, Thinking, Feeling, Behaving, Young Men's Work and Teen Relationship Workbook, 100 Interactive Activities, Living in Balance, and Life Skills 225 Workbook. The program's mental health and substance abuse clinical staff consist of one licensed psychologist under Chapter 490, Florida Statutes, who serves as the designated mental health clinician authority (DMHCA), two psychiatrists, one licensed mental health counselor (LMHC), and five non-licensed master-level therapists. The program's clinical staff provides supportive counseling sessions as outlined within each youth's treatment plan. Seven staff training records reviewed, determined each staff has received intense mental health treatment services training. The DMHCA and LMHC are each on-site forty hours a week. The two psychiatrists share clinical duties and are on-site at least two days a week. The non-licensed therapists are on-site five days a week with a rotating weekend schedule for on-site coverage seven days a week.

An interview with the DMHCA confirms he conducts psychological evaluations of referred youth to address intelligence quotient levels, diagnostic and treatment issues, and recommendations. The evaluations include psycho-educational and personality/psychopathology instruments, and

on an as needed or requested basis. The DMHCA conducts individual, group, and family therapy sessions and initiates and signs involuntary professional Baker Act evaluation forms. An interview with the program director revealed the program offers Intensive Mental Health Treatment Services for fifty-six youth. These youth receive weekly individual sessions and the scope of services focusing on mental health services for youth with moderate mental health issues.

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

A total of seven youth records were reviewed for psychiatric service delivery. Three of the seven youth were on prescribed psychotropic medications upon admission. The remaining four youth were applicable for referral of psychiatric services. All seven youth were subsequently seen within fourteen days of the referral. Each of the initial diagnostic psychiatric interviews included a youth history, mental status examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), treatment recommendations (if applicable), prescribed medications (if applicable), explanation of the need for psychotropic medication, and frequency of medication monitoring. All seven initial diagnostic interviews with the psychiatrist were documented on the Clinical Psychotropic Progress Note (CPPN). One of the seven initial psychiatric diagnostic interviews resulted in changes to youth's existing psychotropic medication regimen. Page three of the CPPN was used to document the initial psychiatric interview. Three youth entered the program on psychotropic medication and three youth were prescribed psychotropic medication after their admission. Each of the six applicable youth were in receipt of a psychiatric evaluation with thirty days of referral. Each of the psychiatric evaluations conducted reflect the elements specified in Florida Administrative Code 63N-1. Each of the six applicable youth receiving psychotropic medications, were being seen for medication monitoring review by the psychiatrist every thirty-days. The psychiatric evaluation was found to be documented on the CPPN (all three pages).

The program has an independent contract agreement with both psychiatrists providing services. The psychiatrists are available for emergency consultation twenty-four hours a day, seven days a week. The program does not employ a psychiatric advanced practice registered nurse (APRN). The psychiatrist's evaluation and recommendations for the youth is incorporated into the mental health clinical staff's evaluations of the youth and the youth's individualized mental health or substance abuse treatment plan; as noted within the six applicable youth records reviewed who were on prescribed psychotropic medications. A review of sign-in sheets for the two psychiatrists confirms they were on-site for the required hours according to the contract for the past six months. The psychiatrist is ultimately responsible for the prescription and monitoring of psychotropic medications at the program. A review of youth records revealed the psychiatrist actively participates in, manages, and supervises psychotropic medication service within the program. The review of youth records demonstrates the two psychiatrists personally render psychiatric services within the program.

An interview with one of the program's psychiatrist was conducted to determine his role in the coordination and implementation of the psychiatric services provided. The psychiatrist reports

previous evaluations such as the comprehensive evaluation (usually performed in detention) are reviewed by the psychiatrist prior to the initial appointment. All youth new to the program undergo an initial psychiatric intake examination with a psychiatrist. Following this examination, pertinent labs, medical referrals, and psychometric scales are ordered. If psychotropic medications are indicated, then parent/guardian and youth consent is obtained and documented prior to initiation of medication. All youth placed on psychotropic medications are monitored for side-effects at least weekly by nursing staff and these are reported back to the psychiatrist. All youth who are placed on medications are followed up with the psychiatrist at least monthly. Youth may be seen by the psychiatrist more often when new medications are initiated or there are significant medication changes. The psychiatrist reports he is available to therapists individually for consultation regarding youth at any time. Therapists complete psychiatric update forms notifying the psychiatrist of progress in the program at each clinic visit. Youth records are reviewed during clinical staff meetings including clinical director, nursing, case manager, and facility manager prior to each clinic visit with the psychiatrist. In addition, communication with the DMHCA and program director concerning youth in receipt of psychiatric services, occurs at the program's weekly staff meeting in which discussions occur regarding all youth being seen by the psychiatrist for the week. The formalized procedure in place for healthcare staff to review medical issues pertaining to those youth receiving psychiatric services, is meeting with nursing staff on each clinic day (two days a week). Nursing staff complete documentation recording side-effects which are reviewed by the psychiatrist. Nursing staff attend the clinical staff meeting described above in which the clinical director also attends. This occurs for all youth seen weekly. Nursing staff places any youth requests to be seen or medication refusal forms in the psychiatrist's folder which are reviewed at each clinic day (two days a week). The psychiatrist conducted face-to-face communication two days a week. Telephonic communication is conducted as needed. The psychiatrist also reports he generally meets with the primary care medical doctor weekly and the primary care medical doctor is always available by telephone.

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

The program has a written suicide prevention plan, which details suicide prevention procedures. The program's written suicide prevention plan includes: identification and assessment of youth at risk of suicide, staff training (for total of six hours annually, which includes mock drills), suicide precautions, levels of supervision (one-to-one, constant, and close supervision), referral, communication, notification, documentation, immediate staff response, and a review process. The program's written suicide prevention plan is reviewed annually. The last date the plan was reviewed and signed by the designated mental health clinician authority and program director was on January 24, 2020.

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

A total of seven youth records were reviewed for suicide prevention services. Each youth had an Assessment of Suicide Risk (ASR) completed upon admission. The program's written Facility Operating Procedures (FOP) and an interview with the designated mental health clinical authority (DMHCA)confirms all youth will be assessed for suicide risk upon admission. Each of the seven-youth were assessed for suicide risk upon admission. An ASR referral was generated for each of the youth utilizing the required Department's ASR form. Five out of the seven youth were placed on standard supervision. The remaining two youth were placed on constant supervision. In all the youth screened for suicide risk, authorization for placement was approved. Mental health staff conduct ASRs and provide supportive services to the youth. Two youth were applicable for completion of a Follow-Up ASR. The Follow-Up ASR included all elements required by Florida Administrative Code. In each of the youth's ASR screenings, the program director and licensed mental health professional held a meeting to reduce level of supervision. The two applicable youth who were maintained on constant supervision, had documented date and time they were stepped down to close supervision. Discontinuation of close supervision was documented in accordance with the program's written suicide prevention plan. All youth records reviewed indicated the parent/guardian was notified of the youth's ASR results. Documentation for notification to the parent/guardian and juvenile probation officer (JPO) was found on the Department's ASR form. The program's FOPs address notification to the JPO and the parent/guardian of a youth's potential suicide risk. Each ASR conducted was completed by a licensed mental health professional or clinical staff under the supervision of a licensed mental health professional. Each of the seven reviewed youth for completion of ASR screenings, were completed by the program's master's-level therapist, then subsequently reviewed and signed off by the program's licensed mental health counselor (LMHC). The two applicable youth who were placed on constant supervision had a completed suicide alert initiated within the Department's Juvenile Justice Information System (JJIS). Upon each of the youth being stepped down from precautionary observation (PO), the alerts were removed from JJIS. Placement of a youth on PO allows each youth to participate in select activities with other youth in designated safe housing/observation areas of the program. Placement of a youth on PO does not limit the youth's activity to an individual cell or restrict the youth to their sleeping room. Each of the non-licensed clinical staff completing ASR screenings, had documented twenty hours of training by a licensed professional on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in ASR form. There was evidence within the facility logbook and on the ASR, where administrative or supervisory staff provided instructions related to the suicide risk assessment findings and suicide precautions decisions. Each of the seven ASR screenings were conducted within twenty-four hours of referral. In two applicable youth reviewed, the shift supervisor provided a list of youth on PO and passed along to the next shift during shift briefing. Five applicable youth whose ASR determined the youth is not a potential suicide risk, were transitioned directly to standard precautions. Two applicable youth whose

ASR indicated potential suicide risk were maintained on suicide precautions (constant supervision), until the Follow-Up ASR screening indicated suicide precautions may be discontinued. The Follow-Up ASR screenings were completed on the Department's Follow-Up ASR form. In each of the two applicable youth cases, once the Follow-Up ASR indicated suicide precautions may be discontinued, each were stepped down to close supervision prior to transitioning to standard supervision. In each of these youth cases, it was determined by the LMHC no longer necessary to be maintained on close supervision and were transitioned to standard supervision. All seven-youth had documentation on the ASR, where the licensed mental health professional conferred with the program director or designee, prior to revising the supervision level. Documentation of the actual date and time the clinician conferred with the program director or designee was found on the ASR in appropriate sections. No youth screened for suicide risk were found to be in crisis. None of the reviewed youth required an ASR to be conducted outside of the program. The program has a written FOP which allows for the utilization of secure observation; however, the program has not had any youth requiring secure observation since last annual compliance review. The program has suicide response kits on-site. Each of the suicide response kits contained: knife-for-life, wire cutters, and needle nose pliers. The program has a written suicide prevention plan, written mental health crisis intervention plan, and written emergency mental health and substance abuse services plan, which address practices for suicide prevention services. The program's written plans address the facility administrator's review process for every serious suicide attempt or serious self-inflicted injury. A multidisciplinary review includes, circumstances surrounding the event, facility procedures relevant to the incident, training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

Seven staff were interviewed and responded they would notify mental health staff, search youth and room for sharp objects, provide constant sight and sound, document supervision, and notify mental health staff should a youth express suicidal thoughts. All seven staff were able to identify locations of the program's suicide response kits.

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.	

A total of twelve precautionary observation (PO) logs were applicable and used for each of the three applicable youth records reviewed. All twelve PO logs reviewed were documented on the Department's Suicide Precautions Observation Log form. Each of the twelve PO logs, were maintained for the duration the youth was on placed suicide precautions. The PO logs documented the appropriate level of supervision and observations of the youth's behavior for duration of time on supervision. There were no noted or need to document warning signs in any of the twelve PO logs reviewed. Staff recorded observations of youth behaviors in real time, at a minimum of thirty-minute intervals. All the PO logs were reviewed, were signed off by each shift supervisor. Each of the PO logs were reviewed and signed off by the mental health clinical staff. All the PO logs included specific language documenting safe housing areas within the program. Each of the three youth were interviewed separately and asked while they were on suicide precautions were staff always with them; each youth responded yes. The youth were also asked, if they were ever left alone for any period; each youth responded no.

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.	

Seven staff training records were reviewed for suicide prevention training. All staff completed appropriate annual training related to suicide prevention training, except one staff did not complete the two hour training requirement in the Department's Learning Management System (SkillPro) and another staff did not receive four hours of instructor led training. The program has three operating shifts. A review of fifty percent of direct care staff found the program completed a mock suicide drill quarterly and on each shift for the annual compliance review period. Each of the reviewed mock suicide drills included the use of cardiopulmonary resuscitation (CPR). Staff members who are not present during a quarterly drill have the opportunity to review each drill scenario and procedures.

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. The written crisis intervention plan includes the following: notification and alert system, means of referral (which includes, youth self-referral), communication, supervision (one-to-one, constant, and standard supervision), 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 did not have any youth requiring a crisis assessment during the annual compliance review period or since the last annual compliance review was conducted. The program has a written crisis intervention plan and emergency mental health and substance abuse plan, which addresses those practices necessary to effectively handle youth in need of a mental status exam and crisis assessment. The program utilizes the Department's Crisis Assessment form, to document reasons for assessing a youth demonstrating acute psychological distress.

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. The written emergency mental health and substance abuse plan includes, the following: immediate staff response, notification, communication, supervision, authorization to transport for emergency mental health services or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statutes (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statutes (Marchman Act), documentation, training, and a review process.

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

The program had one youth applicable for completion of a Baker Act referral for this annual compliance review period. The Baker Act reviewed provided information as to the how and when the youth was determined to need emergency care. Staff responded by reporting to mental health clinical staff and placing the youth immediately on suicide precautions. The youth was placed on one-to-one supervision at the time of discovery. Mental health staff were involved provided notification and support to the youth and staff. The youth was taken out of the program for Baker Act services. The transport for the youth receiving Baker Act services, was authorized by the licensed mental health clinician (LMHC) and program director. The youth was transported by local law enforcement. When the youth returned to the program, he was placed on constant supervision at admission. A mental health referral was generated, indicating a mental status examination will be conducted. An Assessment of Suicide Risk (ASR) was conducted by or under the direct supervision of a licensed mental health professional. The youth was maintained on constant supervision until he was properly transitioned to a lower level of supervision. The youth’s level of supervision was not lowered until the appropriate assessment was completed and the mental health staff conferred with the licensed mental health professional and the program director or designee.

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's designated health authority (DHA) is a licensed osteopathic physician (DO) who holds an unrestricted license which expires on March 31, 2020 and meets all requirements for independent and unsupervised practice in Florida. The DHA's specialty training is in internal medicine with experience in adolescent health. The DHA does not designate a physician assistant (PA) or advanced practice registered nurse (APRN). The DHA is on-site at least once a week, as verified through observations of sign-in sheets for the previous six months. According to contractual requirements, the DHA must be on-site once a week for two hours. A review of the sign-in/sign-out logs revealed no issues. Observations reflected the DHA is on-site Monday through Friday as required. If the DHA is on vacation or scheduled absences, a medical doctor (MD) has been designated to cover these absences. A copy of the MD's credentials was available for review and reflected an expiration date of January 31, 2021. The DHA is responsible for communication with program staff regarding youth medical needs and has availability for consultation by electronic means twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The DHA reported he is responsible for completing Comprehensive Physical Assessments (CPAs) on all newly admitted youth, assessment and renewal of medication for chronic conditions, and health complaints which need to be address by a physician. Additionally, the DHA reported he is on-site every weekday and on-call twenty-four hours a day, seven days a week.

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

The program has written policies and procedures for all health-related procedures and protocols utilized at the program. The designated health authority (DHA) and facility administrator sign and date all respective treatment protocols and Facility Operating Procedures (FOPs). Nursing staff review, sign, and date a cover page on which all FOPs, treatment protocols, and other procedures are listed. New policies, or changes in policies, made during the year are reviewed, signed and dated by each nurse on the individual policy changes which occur between annual compliance reviews. The FOPs and protocols are reviewed annually. All newly employed health care personnel, receive a comprehensive clinical orientation to the Department's health care policies and procedures, given by a registered nurse. Approval of treatment protocols and standing procedures are written and authorized by the DHA and are not delegated to any other person. The review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management is performed by the program's psychiatrist.

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

The program has a written policy and procedures to ensure, to the fullest extent possible, parents/ guardians are afforded the right to give or withhold consent with regard to health care provided to their children. Seven youth Individual Healthcare Records (IHCRs) were reviewed

for an Authority for Evaluation and Treatment (AET). Four of seven records reviewed contained an AET. Each AET was stamped "copy" in either blue or red ink. Two of seven youth reviewed were over the age of eighteen, in which case, a Release of Information Authorization Form for Youth Eighteen Years of Age or Older form was observed in both records. One of seven records contained a court order, as the youth was in the care of the Department of Children and Families, where there has been a termination of parental rights. Copies of the parental notifications were observed to be maintained behind the AET in the IHCRs. The registered nurse reported, AETs are verified for all projected intakes, if there is not a valid AET on record, case management staff will be contacted to reach out to the youth's assigned juvenile probation officer for assistance.

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

Seven youth Individual Healthcare Records (IHCRs) were reviewed for parental consent. Two of seven records reviewed were applicable for parental notification for over-the-counter (OTC) medications beyond those listed on the Authority for Evaluation and Treatment (AET). Documentation reflected both applicable records contained parental notification. None of the seven youth reviewed were applicable for vaccinations and immunizations. None of the seven youth reviewed were applicable to significant changes to existing medication. Three applicable records reviewed reflected notification for discontinuation of medication prescribed prior to youth entering custody of the Department. Two applicable records reflected notification for off-site medical treatment. None of the youth were applicable for hospitalizations, surgeries, invasive procedures or non-routine dental procedures. Documentation in the chronological progress notes reflected staff members witness phone calls and conversations. Four youth applicable for psychotropic medication reflected parent/guardian consent on page three of the Clinical Psychotropic Progress Note (CPPN). All four applicable records reflected the CPPN had been mailed out for parent/guardian signature. One youth record reviewed was applicable for involvement with the Department of Children and Families due to parental rights being terminated, in which case, a court order authorizing treatment was observed in the youth's record, along with written notification. All youth admitted to the program have their immunization records verified within thirty days of admission through Florida Shots and school records. None of the youth reviewed were applicable for refusing consent or refusing consent due to religious reasons. According to the registered nurse (RN), immunizations are verified upon admission for each youth through Florida Shots and/or school records. Additionally, the RN reported, in the event of exemptions from immunizations, the parent/guardian must provide a copy of the exemption form filed with the Health Department to the program.

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

The program has a written policy and procedures in place ensuring youth receive routine health care screenings and evaluations upon admission to the program. Seven youth Individual Healthcare Records (IHCRs) were reviewed for completion of a Facility Entry Physical Health Screening (FEPHS). Documentation in all seven records reflected a FEPHS was completed by a registered nurse (RN) on the day of admission to the program. None of the youth reviewed were applicable for a rescreening.

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

The program has a written policy and procedures establishing a system in place for all youth to be oriented to the program's health care system upon admission or the next available opportunity. Seven youth Individual Healthcare Records (IHCRs) were reviewed for health care orientation. Documentation in all records reviewed reflect each youth received health care services orientation on the day of admission to the program. The program's health care orientation included the following: access to medical care, sick call, medication monitoring, what constitutes and "emergency," the right to refuse, what to do in the event of sexual assault, and the non-disciplinary role of healthcare providers. A signed and dated receipt of healthcare orientation was observed in all records reviewed.

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

Seven youth Individual Healthcare Records (IHCRs) were reviewed for designated health authority (DHA) notification. Four of seven youth reviewed were applicable for DHA notification for a known or suspected chronic condition. None of the seven youth reviewed required notification for need of emergency medical care. The program's practice is to notify the DHA for all new admissions to the program. Documentation of DHA notification was observed in the chronological progress notes in all IHCRs reviewed.

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

Seven youth Individual Healthcare Records (IHCRs) were reviewed for completion of a Health-Related History (HRH). Documentation in all records reviewed reflected a new HRH was completed by a registered nurse (RN) on the day of admission. Documentation further reflected the designated health authority (DHA) reviewed the HRH for all seven youth. All HRHs were completed prior to the Comprehensive Physical Assessments (CPAs). According to the registered nurse (RN), the HRH is completed by the nurse on duty during the initial intake.

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

The program has a written policy and procedures to ensure youth receive physical health evaluations subsequent to admission to the program. The program uses the Department's Comprehensive Physical Assessment (CPA) form. Seven youth Individual Healthcare Records (IHCRs) were reviewed for completion of a CPA. Documentation in all records reviewed reflect the DHA completed a new CPA on each youth within seven days of admission to the program. Four of seven youth entered the program as a medical grade five, two entered as a medical grade two, and one entered as a medical grade one. Each CPA was observed to be completed in accordance with requirements. New CPAs are completed for all youth entering the program.

All sections of the CPA were observed to marked with an "O" or an "X" and included DHA comments where applicable. All seven youth refused the Tanner Stage portion of the examination, in which, "refused" and the youth's signature were observed on the CPA. The Department's Problem List was observed to be updated for all seven youth. The program has a written policy and procedures to ensure all youth receive routine health care screenings and evaluations upon admission to the program for latent or active Tuberculosis as well as environmental controls for the program. The written policy and procedures were observed to be in compliance with the Centers for Disease Control and Prevention new 2006 recommendation and Occupational Safety and Health Standards. Seven of seven IHCRs reflected each youth had a verified tuberculin skin test (TST) completed in the last year. Each youth was assessed prior to being placed in the general population, as indicated by a Tier I B screening completed for each of the seven youth on the day of admission. The results of the TST were observed to be documented on the CPA and Infectious Communicable Disease (ICD) forms in all seven records reviewed. According to the nurse, a new CPA is completed within seven days of arrival and annually. Additionally, the nurse reported a TB screening is completed by the nurse during the Facility Entry Physical Health screening.

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

The program has a written policy and procedures ensuring youth receive sexually transmitted infection (STI) screenings, evaluations, and testing. Seven youth Individual Healthcare Records (IHCRs) were reviewed for STI screenings. Documentation in all records reviewed reflected each youth received a STI screening upon admission to the program. Documentation reflected all youth were referred for testing. Testing, screening, results, clinical evaluation, and diagnosis were found to be documented on the Infectious and Communicable Disease (ICD) form. None of the seven youth reviewed were out of the Department's custody where a re-screen would be required. Referrals for all of the seven applicable youth were documented on the STI screening form. Additionally, testing for all youth reviewed was documented in the youth's progress notes upon admission. Documentation in all records reviewed reflect youth were offered human immunodeficiency virus (HIV) testing, counseling, and referrals for treatment upon admission to the program. Two of seven youth consented to HIV testing. Five of seven youth refused HIV testing. Test results were observed filed in a confidential manner consistent with Chapter 381.004, Florida Statutes, a certified HIV counselor conducted the testing, and a youth's HIV status is never included in the internal alerts. HIV testing and counseling is completed on-site by a HIV certified registered nurse (RN) in which a copy of the 500/501 certification was available for review. Pre and post-test counseling were observed documented in both applicable youth's health education record within their IHCR. Seven of seven youth interviewed reported they can request HIV testing.

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

The program has a written policy and procedures ensuring a system is in place to respond to the complaints of a youth illness or injury of a non-emergent nature. Seven youth Individual

Healthcare Records (IHCRs) were reviewed for sick call. Three of seven youth records reflected youth had completed a Sick Call Request form. None of the three applicable youth presented with a similar complaint three times within a two week period and none had a complaint in which staff was unfamiliar with. All three youth completed Sick Call Request form which were placed in a locked box and then provided to the nurse. Completed Sick Call Request forms were observed filed with the corresponding progress note for each youth, in reverse chronological order. Sick calls reviewed for all three youth were completed by a registered nurse (RN). Sick call is provided twice a day, at 9:00 a.m. and 1:00 p.m., seven days a week and is conducted by a licensed nurse. Sick call times were observed posted throughout the program. Progress notes were observed to be documented in accordance with 63M-2, Florida Administrative Code. Sick calls were observed documented on the youth's Sick Call Index in the IHCR as well as the Sick Call Referral log. Sick Call forms were observed to be available to youth throughout the program. The program has twenty-four hour medical services in which a RN is always on-site; therefore, there is no need for a process to be in place when a licensed nurse in not on-site. One sick call was observed during the annual compliance review. The reviewer obtained the youth's permission to observe the sick call. The youth was escorted to medical by the nurse conducting the sick call, who is a Protective Active Response (PAR) certified staff member. PAR training was observed and verified for this staff member. The nurse identified herself and stated why the youth was there, the youth signed they were seen, the youth was seen in a private area, and proper equipment was present. Seven staff were interviewed in regard to sick calls. All seven staff reported the RN responds to and conducts sick calls. Two of seven youth interviewed reported they are seen for sick call within one day, two reported they are seen within three days, and two reported they are seen for a sick call after more than three days.

4.12 Episodic/First Aid and Emergency Care	**Satisfactory Compliance**
The program shall have a comprehensive process for the provision of episodic care and first aid care.	

The program has a written policy and procedures in place to ensure there is a written plan to provide twenty-four hour emergency medical, mental health and dental care to youth, as needed, in response to unexpected illnesses, accidents or conditions which require immediate attention or an immediate professional assessment to determine their severity. Seven youth Individual Healthcare Records (IHCRs) were reviewed for episodic care. Six of seven youth reviewed were applicable for episodic care. Over-the-counter (OTC) medications were given in three of six applicable records. Education and instruction to the youth were provide for all six applicable youth. One of six applicable youth was referred for off-site care. One of six applicable youth required an alert, in which case, an appropriate alert was entered in the Department's Juvenile Justice Information System (JJIS) and added to the program's internal alert list. Progress notes contained all required elements, needed referrals, parental notification, and plans for follow-up/future care observed. On-site care provided by licensed healthcare staff and subjective, objective, assessment, and plan (SOAP) format was observed. The Episodic Care Log documents all instances of first aid/emergency care. Logs for the previous six months correspond with all on/off-site events observed in youth records. Emergency medical and dental care, including emergency medical services are available twenty-four hours a day. The program has ten first aid kits. First aid kits are located in maintenance, intake, master control, the dorm, medical, kitchen, and four are assigned to vehicles used for transport. The first aid kits were observed to be fully stocked with designated health authority (DHA) approved contents. The first aid kits are monitored weekly by nursing staff to ensure they are secured and to ensure inventory. The program has ten suicide response kits which are located in maintenance, intake, master control, the dorm, medical, kitchen, and four are assigned to vehicles used for transport.

The suicide response kit was observed to contain a knife-for-life, needle nose pliers, and a set of wire cutters. The program has two automated external defibrillators (AEDs). AEDs are located in the dorm and medical. Instructions are located inside the AED. The batteries for the AED located in medical expire in May 18, 2022. The batteries for the AED located on the dorm expire on May 18, 2023. The nursing staff do not remove the batteries to check the expiration dates; however, the staff maintain a log to track dates of expiration of all AED batteries. The AED pads for both AEDs expire April 21, 2020. The registered nurse (RN) performed a self-test on one of the AEDs during the annual compliance review, and it was found to be operational. A review of drill documentation reflected the program has conducted drills monthly and on each shift. Additionally, drills included the use of cardiopulmonary resuscitation (CPR)/AED or the administration of first aid quarterly, and on each shift. The list of emergency numbers, to include Poison Information Control Center, are posted in the nurse's office, which is inaccessible to youth. Three of seven staff interviewed reported they are personally allowed to call 9-1-1 if a youth has a medical emergency. Four of seven staff reported they would notify the supervisor if a 9-1-1 call needed to be made. These results were discussed with facility administration, in which they reported, this will be discussed and reviewed during the next all staff meeting. Five of seven youth interviewed reported they can see a dentist if needed. Two youth reported they cannot see a dentist when needed. These results were discussed with facility administration, in which they reported, dental education and access will be discussed with the youth. All seven interviewed youth reported they can see a doctor when needed.

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

Seven youth Individual Healthcare Records (IHCRs) were reviewed for off-site care. One youth was applicable for emergent off-site care. The program provided two additional records which were applicable for non-emergent off-site care. Parental notification was observed in all three applicable records. The Summary of Off-Site Care form was observed in all three records. Discharge documents were filed in the IHCR of two applicable youth records. Documentation reflected the designated health authority (DHA) initialed all three Summary of Off-Site Care forms. All three youth required follow-up in which the appointments were tracked using an excel spreadsheet appointment tracking log.

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

The program has a written policy and procedures to provide guidance to institutional health services personnel in the areas of chronic illness monitoring and clinic establishment guidelines. Seven youth Individual Healthcare Records (IHCRs) were reviewed for chronic conditions. Four of seven youth reviewed were applicable for a chronic condition. All four youth were identified with a chronic condition on the Facility Entry Physical Health Screening (FEPHS) form. None of the four youth reviewed had a communicable disease. Six of seven youth were taking medication on an on-going basis. Six of seven who entered the program were classified with medical grade two through five. All four applicable youth were observed to be identified as having a chronic illness on the program's internal alert roster. None of the youth reviewed were taking anti-tuberculosis medication. Periodic evaluations are tracked by the registered nurse (RN) using the chronic roster which indicates the dates in which the youth needs to be

evaluated. Periodic evaluation documentation was observed in each youth's IHRC. Evaluations are conducted prior to the renewal of a prescription medication about to expire. Treatment orders were observed to be written clearly distinguishable for clinical staff. None of the periodic evaluations were conducted off-site. There was no indication of any missed or lapsed periodic evaluations in the documentation observed. The Department's Problem List for each youth was updated in accordance with the 63-M, Florida Administrative Code. According to the registered nurse (RN), when youth are identified at intake or by the designated health authority (DHA) as having a chronic condition, they are placed on the tracker to monitor and track due dates. According to the facility administrator, any medical issues are discussed with at the morning management meeting, and any more in-depth issues are discussed with medical staff after this meeting. The DHA reported most chronic conditions are addressed every day and the nursing staff maintains a tracker.

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

The program has a written policy and procedures in place to ensure youth receive all prescription medications as prescribed. Seven youth Individual Healthcare Records (IHCRs) were reviewed for prescription medication. Five of seven youth were taking prescribed medication upon entry to the program. The Prescription Medication Verification forms and Transfer and Receipt of Medication forms were observed in all five applicable records. All medications were observed to have a current, valid order, and are given pursuant to a current prescription. None of the youth records were applicable to restrictive housing. Two of the seven youth were applicable for over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET). Medication in these two records were observed to be administered in accordance with approved protocols. The program utilizes a pre-printed pharmacy Medication Administration Record (MAR). Staff initialed each administered medication. There were no undocumented explanations for lapses or errors in medication administration. Nursing staff document weekly side effect monitoring on the MAR. The Six Rights of Medication Administration are maintained by licensed staff. Three of five applicable youth's MARs reflected refusals, which were clearly documented on the MAR and had a corresponding refusal form. The Facility Entry Physical Health Screening (FEPHS) form indicted all five youth were taking prescribed medication upon admission to the program. Appropriate notifications to the parents/guardians and designated health authority (DHA) were made for four of the five applicable youth. One youth was not applicable for parental notification due to being eighteen years of age or older. All medications were observed to be stored in a separate, secure areas inaccessible to youth. All non-controlled medications (prescribed and over-the counter) are stored in a separate, secure, locked area inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stock items are kept separate from specific youth medications. Expired medication is destroyed once a month, or on an as-needed basis, with Rx Destroyer in the presence of the pharmacist and the health services administrator, who is a registered nurse (RN). The DHA reviews and signs off on the disposal and destruction of expired and discontinued medications. Any expired or discontinued controlled medications are returned to the pharmacy. One medication pass was observed during the annual compliance review in which no issues were noted. Five of seven youth interviewed

stated a nurse gives them their medication and were able to explain the medication administration process; two youth reported they do not take medication. Seven of seven staff interviewed reported the nurse administers the youth medication.

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

The program has a written policy and procedures ensuring all chemical products, drugs and medicines and medical instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. Medical equipment classified as sharps were observed securely stored and inventoried by using a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Medications such as injectables, topicals, drops, and liquids were observed separated. All controlled substances were observed maintained behind two locks, stored separately from other medications, and had a perpetual inventory. The program has a process in place for disposal or destruction of expired and discontinued medications. A perpetual inventory of all sharps and stock over-the-counter (OTC) medications was observed. Pursuant to the Board of Pharmacy regulatory requirements, a shift-to-shift inventory count of all controlled substances was observed documented on the youth's individualized Controlled Medication Inventory Record. A shift to shift count of controlled medications was observed. The reviewer observed the nurse inventory two youth medications, one being a narcotic/controlled medication, three OTC medications, and three sharps all of which matched the perpetual inventory. Perpetual inventories of medications and sharps for the previous six months were available for review. The nurse was able to explain procedures for inventory discrepancies as well as secure storage and routine inventories of medication, disposal of medication, and the practice for securing controlled substances.

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

The program has infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, according to Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control (CDC) guidelines. The program's infection control procedures include the following: common, infection diseases of childhood, self-limiting, episodic contagious illness, viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV, pediculosis and/or scabies, methithicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. Additionally, the hepatitis B immunization is available to staff. There have been no instances in which the local health department, CDC, or the Central Communications Center (CCC) should have been notified. The program has a comprehensive process for needle stick post-exposure evaluation. The facility administrator (FA) or designee will maintain a separate file containing all documents for youth

and staff who have experienced facility exposure, as necessary. The program's Exposure Control Plan was found to be written in accordance with the Occupational Safety and Health Administration standards. Staff are trained annually on the program's Exposure Control Plan. The plan is reviewed and signed annually by the FA. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. The FA reported the Exposure Control Plan is located in the plant manager's office and medical clinic and is reviewed on a regular basis with staff.

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

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

Standard 5: Safety and Security

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

The program's staff to youth ratio is one staff to nine youth during daytime activities, and one staff to twelve youth during hours of sleep. During the annual compliance review, youth were observed attending educational classes as scheduled and participating in meals, breaks, and line movements. Positive interactions were observed between youth and staff. Staff were interviewed and asked to verify the number of youth under their direct supervision and were able to do so. The program has a written policy and procedures which details active supervision for youth. The program's weekly schedule consists of a full schedule of planned activities. Schedules are posted and available for youth in program and living areas. Youth were engaged in a full schedule of activities, and not just sitting around. Staff were observed applying consistent application of the program's behavior management system (BMS). No youth were observed roaming freely. A staff member was questioned about procedures when a count could not be reconciled, and stated they are to stop all movement and radio the transmission; conduct a physical headcount of the youth. All direct care staff who are presently not directly supervising a youth would then need to conduct a search for the missing youth. Once located, and master control has verified the count, normal activities would then continue.

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

The program's behavior management system (BMS) is clearly written and included in the youth handbook. The BMS was observed posted throughout the program and on youth living units. Seven of seven youth records reviewed indicate the BMS was part of the orientation process for newly admitted youth. The rules governing conduct and positive and negative consequences for behaviors were observed in the youth handbook. The program's behavior management system (BMS) was also clearly written and included in the youth handbook. The program's BMS has changed since the last annual compliance review. The program still utilizes a point system but has added the use of daily deal breakers. The addition of daily deal breakers allows youth to continue to earn their points for the day but may result in a loss of incentive for the day. The intent of daily deal breakers is to allow youth to continue to progress in the program rather than lose all of their points for the day as a result of one negative behavior. Observations throughout the annual compliance review reflected a consistent implementation of the BMS by staff to include adherence to the four to one ratio of positive to negative consequences. Negative consequences are in direct relation to the severity or seriousness of the inappropriate behavior exhibited. The program's BMS offers a variety of rewards/incentives. The BMS includes a process for explaining to youth the reason for any sanction imposed and allows opportunity for

youth to explain their behavior. There is opportunity for staff and youth to discuss the impact of behavior on others, alternative acceptable behaviors, and make reasonable reparations for harm caused. The facility administrator (FA) was interviewed and stated the program utilizes the Positive Performance System (PPS), which consists of levels where youth earn different incentives and program activities throughout the day. The system is driven by treatment progress as evidenced by daily earned days, and incentives, and treatment team progressions. Higher levels include on and off campus activities for youth who pass risk assessments. The FA stated rewards for youth are monitored by the recreational therapist who utilizes a tracker. They discuss with the youth any program violations and behavior problems which may prevent them from earning daily, weekly, and monthly rewards. Monthly award ceremonies have been implemented to highlight youth achievements. Consequences are monitored through Deal Breakers, which are major violations including behaviors such as abusive profanity, gang related activity, possession of contraband, and other inappropriate acts. This is tracked and monitored by the recreational therapist and youth advocate, as well as the assistant facility administrators. A tracker is used to document any loss of a day or Deal Breakers received. If a youth has a concern about a consequence received, they are able to utilize Speak Out forms and the grievance process. Seven youth were interviewed concerning the program's BMS. All were able to summarize the level process. All were able to give examples of rewards and incentives, as well as consequences they may earn for behaviors exhibited. Six of seven stated youth are never allowed to punish other youth. One reported some youth do. The BMS was rated very poor by two youth, fair by two youth, good by one youth, and very good by two youth. Seven interviewed staff were able to summarize the BMS process, as well as give examples of rewards and incentives given to youth. All seven staff indicated only privileges can be taken away from youth as a result of negative behaviors exhibited.

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.*	

A review of the program's written policy and procedures for the behavior management system (BMS) ensured there was a protocol where staff are provided feedback regarding their implementation of the BMS. Feedback is delivered through monthly staff meetings, on-going training, and performance evaluations. Seven staff training records were reviewed. All seven staff received pre-service training for the BMS. Six of seven received in-service training for the BMS. A sample of position descriptions were reviewed to verify required qualifications of staff whose job functions included implementation of the program's BMS. A review of the provider's contractual agreement confirmed all required parties were involved in the development, implementation, and on-going maintenance of the BMS. The program does not utilize room restriction as indicated in their policy. The BMS does not include increased length of stay, denial of youth basic right, promotion of group punishment, punishment by other youth, or disciplinary confinement. Education staff are paid for through the provider and are trained in the BMS.

Seven interviewed staff were able to summarize the BMS process, as well as give examples of rewards and incentives given to youth. All seven staff indicated only privileges can be taken away from youth as a result of negative behaviors exhibited. All staff explained youth are informed of the consequences and are able to explain their behaviors. The staff reported they are provided feedback from the supervisors through ways such as coaching, shift briefings, and cards given to them for good performance. Seven youth were interviewed concerning the staff's implementation of the BMS. Five youth explained staff were consistent. Two youth reported staff are not consistent. The facility administrator confirmed violations by youth are reviewed and addressed for consistency and/or inconsistency. The assistant facility administrator and youth advocate review documentation and grievances concerning the system implementation. If necessary, staff will be retrained and/or coached about proper use of the system.

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 192 cameras and all are operational. There are thirty days of video recordings stored. Samples of six periods of time for all shifts were observed for completion of ten-minute observation checks. The samples selected included observation of at least one weekend day. Five of the six documented time periods were observed with staff conducting checks as required. Ten-minute checks were observed and are being conducted in the required frequency and in real time and the checks are met with fidelity; the staff members were observed stopping at each door and looking in the window. Ten-minute checks were reviewed to ensure the actual time of each check and the staff initials were documented. One of the time periods, occurring December 27, 2019 on A Shift, found the staff failed to perform the room checks from 5:45 a.m. to 6:16 a.m. However, the staff did document on the observation form, indicating they had performed the checks at ten-minute intervals. This was reported to the program administration as falsification and was reported to the Central Communications Center (CCC). Seven of seven staff interviewed indicated checks are complete at eight-minute intervals.

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

The program has a written policy and procedures regarding youth census, counts, and tracking. Observations of counts during the review were conducted as required, prior to youth movements, and communicated by radio to master control. A review documentation of logbooks indicated the program is conducting counts at the beginning of each shift, after each outdoor activity, when youth are temporarily away from the program, and during emergency situations, or drills. Seven staff were interviewed regarding youth counts and reported master control calls for head count on a scheduled and unscheduled basis at least three times a shift. Staff further reported if the count is not accurate, a recount is conducted. During an emergency count, the program is locked down and the youth are placed in their rooms and all available staff begin searching.

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.	

Logbooks were bound with numbered pages, and all entries were made in ink with no erasures or white-out areas. There were no logbook entries obliterated or removed. Logbook errors were struck through with a single line and were dated and initialed by the person correcting the error. All entries included the date and time of the event, the name of the staff and youth involved, a brief description of the event, and the signature of the staff making the entry. A shift briefing is conducted for each shift, which summarizes in the report the events, incidents, and activities documented in the program's central logbook. This briefing is provided verbally to incoming staff by the supervisor, and the staff sign and date the report for the previous shift to document he/she has reviewed or has been verbally briefed about the contents. The program documents the following events, incidents, and activities in the central logbook maintained at master control: emergency situations, incidents, special instructions for supervision and monitoring of youth, population counts, perimeter security checks, transports, requests by laws enforcement to access any youth, removal of any youth from the mainstream population, admission and releases, information relating to escapes or attempted escapes were documented in the

logbook. Internal incidents reported to the Florida Abuse Hotline and/or the Central Communications Center (CCC) were documented.

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

The program has a written policy and procedures to govern the use of program keys. The system includes key assignment and usage including restrictions on usage, inventory and secure storage of keys, procedures for addressing missing keys, and reporting on damaged keys. Observations were made of the distribution and collection of keys conducted by the master control operator. The key inventory was reviewed and ensured the inventory matched the actual key rings in use. The key storage area was observed secured in master control. The distribution of permanent and temporary key assignment was observed and in compliance with the program's policy. There were no damaged or missing keys reported based on a review of Central Communications Center (CCC) reporting information. The master control operator was interviewed and stated only assigned staff receive keys for their area work assignment. Medical staff only receive medical area related keys. All keys are passed through master control and a daily log is kept documenting the type of key along with the person possessing it. The log includes sign-in and sign-out times. A sampling of three staff keys was completed to compare their key rings to the key inventory logs with no issues identified. Seven interviewed staff were able to summarize the key control process.

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

The program has a written policy and procedures in place addressing contraband. The program's system to prevent contraband from entering the program includes definitions of what

is determined contraband. Youth are provided a list of contraband or prohibited items. The list is located within the youth handbook, which is given to each youth upon admission. Youth are informed of consequences if found with contraband. Procedures for eliminating contraband include searches of the program, youth, incoming and outgoing mail, and program grounds. The program's contraband policy addresses any staff who is found in possession of contraband in a program will be subject to disciplinary action up to and including dismissal, which includes administrative staff. Law enforcement shall be contacted if any found item would be considered illegal as defined by Florida Statutes. The program documents confiscation of contraband and disposition on the Confiscation of Contraband Log. Documentation is also maintained in the youths' record. Illegal contraband is turned over the law enforcement and notification would be made to the CCC. The facility administrator reported discovery of contraband is tracked and documented in the contraband binder and is maintained in the chief of security's office. Illegal contraband will be documented on an incident report and called into the CCC and local law enforcement. If law enforcement does not confiscate the contraband, it is kept in a secure box at the program.

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 conducts youth searches to ensure no contraband is brought into the program. During the annual compliance review, observations of searches were made before and after transports, after education and vocation instruction, and following access to tools. During the search process, youth were searched by a staff of the same gender. Youth were treated with dignity and respect. The thoroughness of the searches was observed and determined to be conducted according to the Protective Action Response (PAR) training manual. Instructions were given by staff to the youth, explaining the purpose of the search. Seven interviewed youth all confirmed searches take place at the program. The youth stated searches are done in various times such as when returning from off campus activities, if items are missing, after meals, after work detail, after outdoor activities, and after visitation. Seven interviewed staff all confirmed youth searches are done during times of youth movement.

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

Invoices were reviewed which confirmed all vans received an annual safety inspection and any deficiencies were corrected. A random check of personal and program vehicles was conducted, and all were secured and locked. All vans used to transport youth were equipped with a fire extinguisher, a seat belt cutter, a window punch, and appropriate number of seat belts, and the door to the youth passenger area cannot be opened from the inside. The first aid kits and vehicle log books are stored in master control which are placed in the van when used for transport.

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

The program has a written policy and procedures concerning the transportation of youth. The program provides a cellular phone to the transporter when transporting youth. The program maintains a ratio of one staff to five youth for all youth transports. Observations of a transport were made during the annual compliance review to confirm the ratio requirement. No issues were identified. One staff of the same gender as the youth is required on transports. A random check of personal and program vehicles was done and ensured they were locked when not in use. Vehicles used to transport youth were inspected and found equipped with a safety screen separating the front seat compartment from the back seat. Youth are required to wear safety belts during all transports. All staff who operate a program vehicle have a current driver's license. Youth are not permitted to drive program or staff vehicles and are not left unsupervised in vehicles. Only two of seven interviewed staff reported they have participated in a transport of a youth. Both applicable staffs confirm they were provided a cellular phone prior to the transport. All seven staff interviewed denied they are to use personal vehicles to transport youth.

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

The program has a written policy and procedures outlining the audit/inspection process which includes: who is responsible for conducting the weekly security audits and safety inspections, development and implementation of corrective actions warranted as a result of safety and security deficiencies found during any internal or external review, audit, or inspection. The policy also addresses an internal system to verify deficiencies are corrected and existing systems are improved, or new systems are instituted as needed to maintain compliance. The program's policy and procedure met all the requirements of F.A.C. 63E-7.017 (5). A review of sample weekly safety and security audit documents reveals they are being completed every seven days. An interview with the program director reflected there is a clear process regarding the identification, tracking, deficiencies are being addressed by the program through weekly fidelity checks conducted by that assistant facility administrator (AFA) or designee.

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 were observed stored when not in use. All tools were marked for easy identification. All tools are inventoried prior to being issued for work and following work activities. Daily inventories are completed for tools with sharp or pointed edges. Monthly inventories are completed for tools which do not have sharp edges or points. The program prohibits any machetes, bowie knives, or other long bladed knives. The program has procedures for missing or lost tools. Any dysfunctional tools are disposed of and replaced as needed. A review of the inventory used to document the issuance and return of tools was completed with no issues identified. Seven of seven staff training records reviewed determined staff have received training in tool control. Seven interviewed staff report youth are only allowed to use scrub brushes, mops, and brooms.

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

The program has procedures for the supervision of youth handling tools. The program's procedure also addresses issuing tools to youth and staff, including a risk assessment to determine youth's risk to self and others. The procedure also addresses established ratios, tool distribution and collection, and search criteria during work projects. The program maintains a ratio of one staff to five youth during activities involving tools. Risk assessments are completed on youth participating in tool projects or activities. Seven staff were interviewed regarding the tool's youth can use. Six stated a scrub brush, seven stated mops and brooms, and two staff stated other and indicated unless on security alert and youth must still be supervised. Seven youth were interviewed regarding tools they can use. All youth reported being able to use mops and brooms. Some youth reported being able to use vocational tools when working in the Home Builder's Institute (HBI) vocational program.

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

The program has a policy and procedures regarding outside contractors. Sign-in sheets and instruction sheets for outside contractors were reviewed. Guidelines for repairmen and external worker tools include tools checked upon arrival and departure, tool restrictions while in the program, youth are restricted from the work area, and missing tool follow-up. Project invoices submitted to the program by the vendor were reviewed. Documentation reflected the date the project was being worked on matched the sign-in sheets of the outside contractors, which included documentation the program inventoried the tools and equipment upon arrival and prior to departure of the vendor from the program. The program's policy and procedure outlines who is responsible for providing approval/permission if items such as personal cellular phones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are approved for the secure areas of the program.

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 fire drills at least monthly on each shift. Documentation of all drills was obtained. Drill documentation included the type of drill, date, time, participants, brief scenario, findings, and recommendations. The program also conducted other drills such as major disturbance and severe weather drills. Unannounced fire drills were conducted in accordance with the program's Continuity of Operations Plan (COOP), and across all shifts. The program is currently operating on two shifts. Fire evacuation routes were observed posted throughout the program. In addition, fire extinguishers were observed to be inspected annually. The facility administrator was interviewed, and stated fire and medical drills are done monthly for each shift. In addition, COOP drills are done monthly, and escape drills are done quarterly. Mock suicide drills are completed at least quarterly, on each shift. Seven interviewed youth all reported they have been instructed as to what to do in the event of a fire. All confirmed they have participated

in drills. Seven interviewed staff reported they have participated in such drills as weather, fire, major disturbance, bomb threat, hostage situation, flooding, and escape scenarios.

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

The Continuity of Operations Plan (COOP) is readily available to all staff in the breakroom as well as copies available in the office of the assistant facility administrator (AFA) and the facility administrator (FA). The COOP is reviewed and updated annually. The last date of review was on May 3, 2019, and documentation reflected the COOP was signed by the Department's regional director (RD) on May 16, 2019. The plan addresses alternative housing plans approved by the Department's RD. An observation was made of the provision of equipment and supplies required for continuous operation and services during emergency or disaster situations. The COOP includes fire and fire prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The program maintains critical identifying information for each youth in an administrative hard-copy file easily accessible and mobile in the event of an emergency. Each file includes: youth's full name and Department of Juvenile Justice identification number (DJJID), admission date, date of birth, gender, race, name, address, phone number of parent/guardian, name, address, phone number of the person with whom the youth resides and relationship, person(s) to notify in case of emergency, juvenile probation officer name, circuit/unit, and contact, names of committing judge, state attorney, public defender with contact information, notation of whether or not the judge retains jurisdiction, victim notification contract information, physical description of the youth to include height, weight, eye, hair color, overall health status, illnesses, current medications, allergies, personal physician, and photograph. This information was available during the annual compliance review for each youth in a hard-copy.

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 policy and procedures on the storage and inventory of flammable, poisonous, and toxic items and materials. Flammable, poisonous, and toxic items are secured at all times. Flammable, poisonous, and toxic items were all stored in secured areas inaccessible to youth. Inventories were maintained for all flammable, poisonous, and toxic items. The inventory was reviewed and matched the actual items within the program. There were no items missing or additional items not on the inventory. Safety Data Sheets are maintained on-site for all materials and stored with the materials, medical, and master control.

The program has an authorized list of staff positions and titles with access and authority to handle these items.

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

The program has a policy and procedures which address youth shall not handle 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. There is restricted access to areas where items are being used or stored. Seven youth were interviewed regarding access to toxic items and if youth are permitted to utilize hazardous cleaning items. Three of the youth report painting with maintenance or staff.

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

The program has a policy and procedures on the disposal of flammable, toxic, caustic, and poisonous items. The program has an authorized person to dispose these items, who has received training. The program does not participate in the disposal of any hazardous waste. Liquid waste from work detail is disposed of in the plumbing drains. Kitchen waste except grease is disposed of in the kitchen. Grease is placed in a separate container for disposal. The program did not have any chemical spills in the past six months, but the policy and procedures reflect how chemical spills are cleaned-up. Upon becoming aware of a chemical spill, staff shall notify master control of the location. The shift supervisor or master control shall direct the shut-down of all air handlers and ventilation systems and close all windows and doors at the direction of the on-scene supervisor. Assistance from outside the program will be contacted, as necessary, consistent with emergency procedures. The facility administrator was interviewed and stated all contaminated items must be disposed of in a bio-hazardous receptacle.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedure concerning visitation for youth. The program's visitation schedule was observed posted and visible for staff and youth. A review of the visitation, mail, and telephone log and schedule was conducted to confirm the program's practice. In the event parents/guardians are unable to visit during normal visitation times, alternative visitation arrangements may be made available. Youth are given an opportunity communicate with family members through visitation, mail, and telephone calls. Searches of in-coming and outgoing mail is completed by staff in the presence of youth. Each youth receives a youth handbook upon admission, which details visitation, telephone, and mail procedures. Seven interviewed youth all reported they have the opportunity to communicate with their families through these means.

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

The program's controlled observation room meets all Department requirements. Five incidents of the use of controlled observation were reviewed for the scope of the annual compliance review. All five controlled observation reports reflected staff conducted an inspection of the room prior to placing the youth in the controlled observation room and staff of the same gender searched the youth prior to placement. All reports indicated the date and time of placement as well as the date and time of release.

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

The facility administrator designates supervisory or higher-level staff to approve placement of youth in controlled observation. Five incidents of the use of controlled observation were reviewed. None of the five reports reviewed reflect the youth placed in controlled observation were exhibiting signs or behaviors indicative of a mental health crisis or suicide. Authorization for placement in controlled observation for all five reports was made by a supervisory staff or higher. All reports indicated youth who were placed in controlled observation met the required criteria. Documentation in all reports reflected youth were made aware of the reason for their placement in controlled observation. All reports reflected the health status checklist was completed by a staff member of the same gender. All reports reviewed reflect the youth were released from controlled observation in two hours or less. Seven youth were interviewed and asked if they have been sent to their room from punishment reasons. Three of seven reported stated they have not been sent to their rooms. Four stated yes, after they had gotten into a fight. They stated the door was shut and locked. One youth stated it was after a program disturbance, and they were shut in for two days. Program administration was advised of the result of all youth and staff interviews. Administration reported no knowledge of this allegation. The reviewer completed a review of all controlled observation logs, maintained in the log binder, resulting in no incident where a youth was locked in their room on controlled observation for more than two hours.

5.25 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.	

Staff designations for controlled observation are included in the program's written policy and procedures. Five controlled observation reports were reviewed. All five reports reflected the staff making placement completed the first page of the controlled observation report and submitted it to a supervisor. All reports reflected staff conducted and documented safety checks at least every fifteen minutes and observations of the youth's behavior. All safety checks and observations were documented on the Controlled Observation Safety Check form. All reports reflected program director (or designee) approval of release from controlled observation and determinations are made by staff if an internal alert is warranted. The Controlled Observation Report, Health Status Checklist, and Controlled Observation Safety Checks forms are

maintained in an administrative record and in the youth's individual management record. Documentation in each report reflected the facility administrator or designee reviewed the controlled observation report within fourteen days and indicated whether placement was appropriate.

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

The program maintains a safety plan for the youth which is located in a binder within the staff meeting/break room. The plan for each youth includes warning signs, youth's baseline behaviors, crisis recognition, coping strategies, intervention strategies, and a debriefing process. Seven youth safety plans were reviewed. Six of seven were completed within fourteen days of the youths' admission. One youth was a transfer from another residential program, and a new plan was not completed after admission. The plans were documented to all be jointly prepared by the youth and parent/guardian, family member, and clinical staff.