STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Hastings Comprehensive Mental Health Treatment Program & Hastings Substance Abuse Program

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

Review Date(s): October 8-11, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Patrick M McKinstry, Office of Program Accountability, Lead Reviewer (Standard 1)
Joe Berry, Probation, Juvenile Probation Officer Supervisor (Standard 2)
Jill Foy, Office of Program Accountability, Regional Monitor (Standard 5)
Gwen Nelson, Office of Program Accountability, Regional Monitor (Standard 3)
Ken Phillips, Office of Program Accountability, Regional Monitor (Standard 4)
Cynthia White, Probation, Juvenile Probation Officer Supervisor (Interviews)

Program Name: Hastings Comprehensive MH and SA Program
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: St. Johns County / Circuit 7
Review Date(s): October 8-11, 2019

MQI Program Code: 897
Contract Number: R2104
Number of Beds: 34/30
Lead Reviewer Code: 144

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.04 Ten Minute Checks *	
5.26 Safety Planning Process for Youth	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Satisfactory
1.02	Five-Year Rescreening	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	Satisfactory
2.18	Education Transitions Plan	Satisfactory
2.19	Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory
2.20	Exit Portfolio	Satisfactory
2.21	Exit Conference	Satisfactory

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

Indicator Ratings

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

* 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 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

* 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 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 *	Limited
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	Limited

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

Program Overview

The Hastings Comprehensive Mental Health Treatment Program and Hastings Substance Abuse Program is a thirty-four mental health and thirty substance abuse bed program, for thirteen 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 provides comprehensive mental health treatment services for youth diagnosed with a major mental disorder and who demonstrate very serious to severe mental health disorders. In addition, for youth diagnosed with substance abuse disorders, substance abuse treatment is provided. The program fosters each youth by providing the following interventions Teen Relationships, Living in Balance, Life Skills 225, Anger Management for mental health and substance abuse clients, Strategies for Anger Management, Don't let your emotions run your life, Thinking – Believing – Feeling, Anxiety Workbook for Teens, Young Men's Work, Dare to be King, Thinking for Change (T4C), and Impact of Crime (IOC). Additional treatment services provided includes family/individual therapy and groups. Program administration is comprised of a facility administrator, assistant facility administrator, health service administrator, director of clinical services, assistant director of clinical services, chief of security, business manager, and transitional services manager. Case management services are provided by three case managers. Mental health staff at the program includes two therapists, one designated mental health clinical authority (DMHCA), and one psychiatrist. Medical services are offered twenty-four a day, seven days a week and are provided by six registered nurses (RNs) and one designated health authority (DHA). Educational services are provided by the St. Johns County School Board. The layout of the program includes three buildings in which two are utilized for housing areas for the youth and one which is structured for administration, medical, case management, school, and dining areas. The program has a total of one hundred ninety-two cameras in which one hundred ninety are operational providing coverage. At the time of the annual compliance review, the program had eight vacant positions; four youth care workers, one master control operator, one case manager, and two therapists.

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 review of the provider's employee roster revealed there were a total of twenty-two staff requiring an initial background screening. Each of the staff records were reviewed for completion of an initial background screening and all were completed prior to the staffs contact with youth. A criminal history report is reviewed as part of the new staff members hiring process as evident for each of the twenty-two records reviewed. None of the reviewed twenty-two staff background screenings required an exemption prior to working with youth. There was no indication of staff having a break in service as indicated within the Staff Verification System (SVS). Sixteen of the twenty-two staff were direct care applicants and were reviewed for completion of a pre-employment assessment. Each of the sixteen direct care staff had a passing score on the assessment which was documented within their respective employment record. The provider added each employee and/or volunteer to the Clearinghouse employment roster. There was no indication of the program having to complete a background screening for a Department employee being hired by the provider or when a provider employee is hired by another contracted provider company. The program currently does not have any person who assist or interacts with youth on an intermittent basis for less than ten hours and may have access to confidential information. An Annual Affidavit of Compliance with Level 2 Screening Standards was completed, sent, and signed to the Department's Background Screening Unit on December 3, 2018. Teachers who are paid by the school board or funding provided by the school board or Department of Education, received an annual screening which was completed and signed on December 3, 2018. The provider's human resource personnel assess each potential applicant which involves reviewing the Department's Central Communication Center (CCC) person involvement history report, SVS module, and Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) results. The provider has a facility operating procedures which outlines the hiring authority process for employment.

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

A review of the program's employee roster revealed there were a total of five staff who required a five-year background rescreening. All of the staff member's five-year rescreening's conducted

were completed every five years which was calculated from the staff members agency hire date. The reviewed background rescreening's were submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten business days prior to the staff member's five-year anniversary date. The program did not have any volunteers, mentors, and/or interns who required a five-year rescreening since the last annual compliance review.

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

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

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

The provider had a total of seventeen Central Communications Center (CCC) calls since the last annual compliance review. There was a total of seven of the seventeen incidents which were allegedly related to physical, psychological, or emotional abuse. A total of five of the seven alleged incidents were randomly selected for review. Three of the five CCC incidents reviewed had no substantiated findings related to physical, psychological, or emotional abuse. Two of the five incidents were still under investigation. One of the five CCC incidents reviewed; however, did contain a finding sustained for violation of policy. A total of seven staff personnel records were reviewed for adherence to the provider's code of conduct. All of the seven staff reviewed personnel records contained a signed copy of the code of conduct. Each of the staff present during the annual compliance review, indicated having observed postings of telephone numbers for the CCC and the Florida Abuse Hotline.

The program has a written facility operating procedures (FOPs) which addresses incident reporting requirements and child abuse reporting procedures. Staff are instructed to immediately report any knowledge or suspicion regarding an incident of abuse or harassment. Such incidents will be reported to the Florida Abuse Hotline and the CCC for youth eighteen years of age and older. The FOPs identifies how a staff member will address a situation should a youth refuse to make an abuse call is mandated to call the Florida Abuse Hotline if the staff has reasonable suspicion abuse has occurred. In addition, staff will verbally notify the on-duty supervisor once the call to the Florida Abuse Hotline or CCC, as applicable has been

completed. Staff will complete an Internal Incident Report form and forward the completed form to their assigned supervisor once a call has been made to the CCC and/or Florida Abuse Hotline. This is not required if the person has made an anonymous report relating to sexual misconduct and wishes to remain anonymous. All staff are instructed to provide youth with timely telephone access to report allegations of abuse without intimidation or reprisal. Staff should never prevent a youth from self-reporting or making a call to the CCC or the Florida Abuse Hotline. Staff will not prohibit youth in controlled observation from making an abuse call; however, the youth's call may be delayed until the youth is calm and compliant with program rules. Staff will always advise youth to be truthful in their report and should inform the youth they may be held responsible for knowingly making a false report. Staff will verbally notify the shift manager immediately of a youth's request to contact the CCC or Florida Abuse Hotline. The shift manager will attempt to immediately notify the assistant facility administrator (AFA); however, notification is not required in order to proceed with the youth's request to contact the CCC or Florida Abuse Hotline. The shift manager will also assist the youth in making the call by dialing the appropriate telephone number, recording the date and time of call, operator name and number, and provide this information on an Internal Incident Report. The shift manager will then permit youth to be free to communicate with the Florida Abuse Hotline operator. Staff while allowing the youth to call, will maintain sight contact of the youth and remain in an area which allows the youth to freely and confidentially report their allegations. The youth is not required to tell anyone why they made the call. The shift manager will have the youth to complete and sign a refusal form if prior to making the call the youth changes their mind and decides to not make the call. The shift manager will forward the refusal form to the AFA prior to the end of the shift. In addition, the shift manager completes an Internal Incident Report documenting the youth's statement and statements from other observers in the event an incident of abuse or neglect by a staff member is witnessed, suspected, or reported by a youth. The facility administrator (FA) will inquire in daily management meeting if any requests to report abuse or actual abuse calls were made, document findings on daily morning management meeting minutes, and forward all paperwork related to allegations of suspected or known sexual abuse which fall under the Prison Rape Elimination Act (PREA) requirements to the PREA corporate coordinator for review and file maintenance. This shall include the incident report, supplemental statements, date and time of contact with the Florida Abuse Hotline and law enforcement, and any other documents which are pertinent to the case. The program has zero substantiated incidents related to physical, psychological, and or emotional abuse since last annual compliance review.

Interviews were conducted with seven youth. Six of the seven youth stated they felt safe at the program. One youth reported feeling safe with the staff but not so much with the youth. None of the seven youth reported ever being denied of reporting abuse to the Florida Abuse Hotline or CCC if eighteen years of age or older, since they have been at the program. Six of the seven youth stated the staff are respectful while talking with them and other youth. One youth replied some staff do not talk respectful. The youth felt being looked at differently which surrounded race or culture. The youth reference feeling like this to one staff in particular. One youth stated never hearing staff use profanity when speaking with them or other youth, one youth replied once, four youth stated occasionally, and one youth stated often. The youth further explained, the staff was aggravated because the youth would not listen. Another youth stated the staff did not do it intentionally and apologized. One youth reported the staff has used profanity at the youth every day. The youth further stated their case manager uses profanity towards the youth over little things. Three of the youth stated the staff does not use profanity very often and never at the youth. The concerns with those findings as reported by the youth were discussed with program administration. The program responded they would look further into each area in which they had recently addressed a staff member having used profanity in the building. The program

has zero tolerance for staff using profanity and the use of foul or abusive language as pursuant to the program's FOP is considered a major infraction.

Interviews were conducted with seven staff, each were able to explain the process for allowing staff and youth to call the Florida Abuse Hotline or CCC to report suspected abuse. Each of the seven interviewed staff stated they have never observed a co-worker tell a youth they could not contact the Florida Abuse Hotline. Each of the seven interviewed staff stated they have never observed a co-worker use profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth.

An interview with the FA indicated the employee code of conduct discusses items such as proper dress code, call out policy, and the disciplinary process. The disciplinary process includes a breakdown of minor, major and critical infractions and details a matrix of consequences such as coaching, written warning, suspension, and termination. The FA also stated anytime situations such as program disruption, escapes/absconding, medical incidents, mental health and substance abuse incidents, abuse, etc. occurs, the program notifies the CCC within two hours of the incident occurring. All youth have the right to make an abuse call and it is the responsibility of the staff to respond as quickly as possible to these types of request.

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

The program had seventeen Central Communications Center (CCC) calls since the last annual compliance review. Seven of the seventeen incidents were related to physical, psychological, or emotional abuse. A total of five incidents were reviewed. None of the five incidents reviewed were found with substantiated findings related to physical, psychological, or emotional abuse. One of the five CCC incidents reviewed; however, did contain a finding "sustained" for violation of policy. The provider provided internal investigations into each of the five incidents reviewed. There is evidence based upon documentation provided which supports management takes immediate action to address incidents of physical, psychological, and emotional abuse.

An interview with the facility administrator annual training on the incident reporting process to the CCC and/or Florida Abuse Hotline occur with all staff. In addition to the training, signage is posted throughout the facility and on the youth living quarter so the youth understand their rights to live in an abuse free environment and what
numbers they can call if needed. For tracking purposes, CCC/abuse incidents are discussed during every morning meeting, a CCC report is sent to staff daily, and a CCC tracker is sent to staff weekly.

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

The provider had a total of seventeen Central Communications Center (CCC) calls since last annual compliance review. A sample of five CCC reports were reviewed. In four of the five

reports reviewed, the CCC was notified within two hours of the program becoming aware of the incident. The remaining incident was reported to the CCC by an anonymous caller. Four applicable CCC reports were documented in the provider's logbooks. The remaining CCC report was not, as it was reported to the CCC by an anonymous caller. There were no indications of any internal incident reports and/or grievances which should have been reported to the CCC. While on-site the Monitoring and Quality Improvement team found documentation of ten-minute checks verification revealing discrepancies which should have been reported to the CCC. A call was made to the CCC to address those issues found while on-site. The program has seen a decrease in the total number of reportable incidents to the CCC since the last annual compliance review. The facility administrator was able to explain the program's incident reporting process by stating anytime situations such as program disruption, escapes/absconding, medical incidents, mental health and substance abuse incidents, abuse, etc. occur, the program notifies the CCC within two hours of the incident occurring. All youth have the right to make an abuse call and it is the responsibility of the staff to respond as quickly as possible to these types of request.

1.06 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 provider had a total of seventeen Protective Action Response (PAR) interventions within the last six months. A sample of five PAR reports were reviewed. Four of the five PAR intervention reports were completed by the end of the staff member's workday. The one remaining PAR report was missing one of the staff members written report altogether. Four of the five PAR reports included statements from all staff involved. None of the reviewed PAR interventions required the use of mechanical restraints. None of the five PAR interventions resulted in any injury to a youth or staff. None of the PAR interventions documented allegations of abuse made by youth or staff. Each of the PAR reports had a review completed by a PAR certified instructor or supervisory staff. None of the reports indicated a PAR medical review was necessary. Each of the reports indicated a post-PAR interview was conducted with the youth by the administrator or designee as soon as possible but no longer than thirty-minutes after the incident. Each of the PAR reports were reviewed by the administrator or designee within seventy-two hours of the reported incident, excluding weekends and holidays. A copy of the PAR reports are placed in the program's centralized file within forty-eight hours of being signed by the administrator. The program submits a monthly summary of all PAR incidents to the Department by the fifteenth of each month. The program's PAR plan was approved by the Department. The program did not have an increase in the number of PARs since the last annual compliance review.

The facility administrator (FA) was able to explain the process for monitoring PAR incidents and use of force. The FA indicated the chief of security or designee reviews all PAR incidents via video. All PAR incidents are discussed during the morning management meetings. During all campus meetings, administration discuss ways to avoid using physical interventions and emphasize the use of verbal de-scalation. All PAR reports are sent out by the fifth of every month. The program's PAR rate during the annual compliance review period was 1.66, which is above the statewide Residential PAR rate of 1.59.

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.	

A review of pre-service and certification requirements were reviewed for this residential contracted provider. A sample of seven staff training records were reviewed. All seven staff reviewed were certified within 180 days of their respective hire dates. Each of the seven staff completed a minimum of 120 hours of pre-service training. All reviewed seven staff completed cardio pulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and Protective Action Response (PAR) training. In addition, each of the seven staff completed professionalism and ethics to include standards of conduct, suicide prevention/intervention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) training. Each of the seven staff completed active shooter training which is not required. Seven staff training records were also reviewed and included evidence of completion for contract specified training in areas for restorative justice, gender-specific services, universal precautions, and emergency evacuation procedures. The program provided the following enhanced treatment need specialized training for staff working with youth who are or with substance abuse treatment services and comprehensive services for major disorders. All seven staff reviewed had documentation to support having received this type training. All seven reviewed staff training records indicated completion of training requirements within the Department's Learning Management System (SkillPro). All instructors are qualified to deliver the training provided. The program submitted in writing, a list of pre-service training to the Department's Office of Staff Development and Training which includes course names, descriptions, objectives, and training hours for any instructor-led training based on the above topics. The pre-service training plan was submitted on January 1, 2018.

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

A review of in-service training requirements were reviewed for this residential contracted provider. A sample of seven staff training records were reviewed to verify in-service training requirements completed. A sample of four direct care and three supervisory staff were selected for review. Each of the reviewed seven staff records received at a minimum of twenty-four annual training hours. Two of the reviewed seven staff records received cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED) training for calendar year 2018. The remaining five staff did not have the aforementioned training until calendar year 2019. All reviewed seven staff records completed a Protective Action Response (PAR) update training. All staff reviewed records had training in professionalism and ethics to include standards of conduct. Each of the staff completed suicide prevention training. Two of the three reviewed supervisory training records included at a minimum eight hours of additional training in areas specific to management, leadership, personal accountability, employee relations, communication skills, and/or fiscal training. The one supervisor had a total of six hours of supervisory training. All instructors are qualified to deliver training provided. The program submitted in writing a list of in-service training to the Department's Office of Staff Development

and Training which included course names, descriptions, objectives, and training hours for any instructor-led training based on the above topics on December 18, 2017. The program has an annual in-service training calendar which is updated as changes occur. The provider hires youth care workers which are staff considered to be direct-care staff and are counted for in the staff to youth ratio. On occasion, if necessary other facility staff such as case managers, nursing, therapist, and administration, if PAR certified may provide supervision; however, typically are not included within standard ratio requirements. Six licensed nursing staff were found to have current certifications in CPR with AED.

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 which include the training requirements of the grievance process. A review of a sample of seven staff training records determined they received the required training on the program's grievance process and procedures. The program's grievance process includes the informal, formal, and appeal phases. During the informal phase, program staff encourage youth to resolve questions, disputes, and complaints through informal communication with program staff. Every reasonable effort is made to discuss the youth's concerns or complaint and assist the youth to informally resolve the issue. No youth may be discouraged from filing a grievance, if the youth wishes to do so. Staff will use active listening skills, encourage respectful conversation, and the opportunity for youth to express feelings regarding the conflict. The informal phase is to encourage, promote open communication, and to assist the youth in the development of improved problem resolution skills. The informal phase should be handled expeditiously but no later than seventy-two hours from when the youth submitted the informal complaint, excluding weekends and holidays. A formal written grievance may be filed with the grievance officer and/or youth advocate at any time. Grievance forms are made available in each housing area. Youth may request the assistance of staff, family, peers, or other advocates to fill out a grievance form. The program shall accept grievances from third parties such as parent/guardians, advocates, juvenile probation officers, and anonymous sources. All grievances shall be deposited by the youth in the designated grievance box within dining halls A and B, where all youth have access daily. The deposit location shall be one which is secure to prevent the removal of a grievance form. The youth advocate or designee shall be the designated person to retrieve grievances. The youth advocate will investigate all grievances received and render a decision in writing to the youth within seventy-two hours. If the decision does not support the youth's grievance, it will be immediately forwarded to the facility administrator (FA). The appeal phase begins upon receipt of the grievance by the FA. Within seventy-two hours the FA will review the findings of the grievance officer or designee to determine whether the unsupported finding is appropriate. If unsupported finding is appropriate, the FA initial the grievance form and return it back to the grievance officer or designee for processing with the youth. If the FA disagrees with the findings, the FA will direct the grievance officer to revise the findings accordingly.

The program maintains copies of the grievances for the past twelve months. The program had sixteen grievances for the past twelve months. A sample of five grievances were reviewed. Each grievance contained the nature of the grievance. All five reviewed grievances documented the informal phase. Each of the grievances documented the date of the grievance and date of

response conducted at the formal phase. All five grievances documented the grievances were resolved at the formal phase. Four of the five reviewed grievances were responded within specified time frames according to the program's policy and procedures. The one grievance was addressed and resolved outside the program's seventy-two hour time frame. During the program tour, grievances were located and accessible to youth throughout the building. In accordance with the program's policy and procedures, staff ensures any youth requesting to file a grievance be given the proper forms, assistance, and instructions on the preparation and submission of the grievance. A review of seven staff training records revealed, staff have been trained in the program's grievance process.

Five out of seven interviewed youth were able to explain the program's grievance process. One youth stated, they did not know about the grievance process. The remaining youth stated they have filed three grievances and heard back on one and was moved to another housing area. All seven interviewed youth reported they can ask for assistance when completing a grievance form. Seven staff were interviewed and was able to explain the program's youth grievance process. Each staff was able to provide basic information pertaining to those practices necessary for assisting youth in the grievance process. The FA was able to explain the program's grievance process. The FA stated the first phase is speaking directly to the staff, the second phase is a "Let's Talk" form, and the third phase is the formal grievance form process. An appeal can always be made to the FA if the decision is found unfavorable.

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

The program has eight staff whose regularly assigned job duties include the implementation of a specific intervention and/or curriculum. Each of the eight reviewed staff training records have been trained in a specific delinquency intervention model. All training reviewed for each staff noted the staff's date of training. A review of the eight staff members personnel records noted each of their level of education. Each staff had a number of years of experience working with adult or juvenile offenders. Administration considered the education and work experience when determining staff delivery of delinquency intervention services. A review of the provider's contractual agreement revealed the required delinquency intervention services to be Impact of Crime (IOC) and Thinking for a Change (T4C). The IOC curriculum is a promising practice and the T4C curriculum is an evidenced-based intervention. The program's written description addresses delinquency intervention strategies. A review of the program's activity schedule determined the program provides structured, planned programming, or activities at least eighty-percent of the youths' awake hours, as prescribed by the contract. A review of group sign-in sheets for both T4C and IOC demonstrate groups are being delivered as indicated on the program's youth activity/group schedule. A review of seven sample staff training records was conducted, each of the staff were trained on the promising practice, IOC. Seven youth performance plans were reviewed for involvement in a delinquency intervention. Each of the seven youth were participating in a minimum of one of the program's delinquency interventions. Each of the youth was involved in a delinquency intervention addressing an identified priority need. The youth's performance plans addressed an identified priority need.

The facility administrator (FA) was able to explain how a staff members education and work experience were considered when determining which staff would deliver life skills trainings and/or groups. The FA stated, all of the program's life skills training is provided by case managers, therapist and recreation therapist. A review of staff's education and background is conducted to ensure they meet all requirements. This process is a collaboration between HR and the Department Head. Staff who hold special certifications are held accountable for any recertification needed to maintain their certification status. The FA indicated the T4C curriculum concentrates on changing the criminogenic thinking of offenders and IOC focuses on awareness about the impact of crime on victims, while providing a safe space to discuss feelings and concerns. Each youth and staff are matched when a pre-classification meeting takes place before receiving a new youth or once the youth arrives to the facility. A series of assessments are conducted and a determination is made about the assigned case manager and therapist.

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

A review of the provider's contract of required services for interventions or instruction focusing on developing life and social skill competencies in youth are Teen Relationship Workbook, Living in Balance, Life Skills 225, Anger Management for mental health and substance abuse clients, Strategies for Anger Management, Don't let your emotions run your life, Thinking – Believing – Feeling, Anxiety Workbook for Teens, and Thinking for a Change (T4C). The youth receive life and social skill intervention services which specifically address at a minimum communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking to include problem-solving and decision making skills. The program's process to determine how services are provided is each youth's needs are identified and prioritized through a comprehensive need assessment. This is completed by a multidisciplinary intervention and treatment team staffing. The treatment team identifies each youth's criminogenic risk and protective factors, prioritize the youth's criminogenic needs, determine the youth's risk to re-offend, and what specific interventions are necessary. Youth are assigned to a multidisciplinary intervention and treatment team and assigned a case manager and therapist for service delivery. The program has a written policy and procedures which determines how the services are provided. A review of the program's activity schedule demonstrates the youth are in receipt of life skills education, training, and/or groups, as required. Upon review of group sign-in sheets, it was determined the program's life and social skills are being delivered according to the program's group/activity schedule.

An interview with the clinical director confirmed their role in the coordination of services at the program by overseeing the delivery of all clinical services including individual, family, and group therapies as well as the development of documentation including comprehensive evaluations and treatment plans/reviews of youth in the program. This is accomplished by providing clinical services via group, individual, and family therapies as needed.

Seven youth were interviewed and were able to identify groups they were in and what they have learned while participating in the groups. Each of the youth also described some of the new skills or behaviors they had been taught while in groups. Six of the seven interviewed youth were able to provide examples having practiced skills while in group and one remaining youth was not able to provide examples of having practiced skill while in group.

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

The provider's contract addresses services for implementation of restorative justice awareness for youth. The program's restorative justice environment holds youth accountable for their behavior to include the harm their crimes caused to the victim(s) and community. The program will offer youth opportunities for competency development in skill areas valued by the community in preparation for reintegration into the community. In addition, the program will foster a restorative community which creates a culture for youth and staff to be actively involved and give input, participate in decisions, practice leadership, and contribute to the community. The program will also facilitate the Impact of Crime (IOC) to youth in order to assist them in accepting responsibility for the harm they caused and educate them on the impact of crime; thereby, instilling empathy for others. All aspects of the program shall reflect the restorative justice philosophy which includes case planning, competency development, community service, and victim and community involvement.

Restorative justice activities or instruction implemented at the program are designed to assist youth to accept responsibility for harm they have caused by their past criminal actions, and challenging them to recognize and modify their irresponsible thinking such as denying, minimizing, rationalizing, and blaming victims. The program teaches youth about the impact of crime on victims, their families, and their communities. In addition, expose youth to victim(s) perspectives through victim speakers. Programming provides opportunities for youth to plan and participate in reparation activities intended to restore victims and communities. Reviewed training records of staff conducting restorative justice awareness groups and activities. A review of the program's activity schedule confirmed staff are trained in curriculum.

Seven youth records were reviewed for delivery of restorative justice awareness. Six of the seven youth reviewed are receiving services to increase accountability for criminal actions and harm to others and are enrolled in IOC course. The remaining youth have already completed IOC. Each of the seven youth are involved and participate in daily programmatic activities which foster restorative justice principles. A cognitive community group was observed. The cognitive community is designed to assist a youth to restrict thoughts, develop cognitive skills, make healthy decisions, and make a correlation between thoughts and actions. The community provides for structure, routine, accountability, responsibility, pro-social lifestyle, support and encouragement from peers, and job readiness. The observed group was well received from each of the youth and community, whereas each youth actively participated.

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.	

A review of the provider's contractual agreement for gender-specific programming is Young Men's Work, Teen Relationships, and Dare to be King curriculums. The program has a program model which addresses the needs for a male population. The program designs specific service delivery based on the common characteristics of its male population. The program's activity schedule provides gender-specific programming. A review of sign-in sheets and an informal

interview with staff discussed gender-specific programming, the program is delivering according to the program's group/activity schedule. An interview with the facility administrator was conducted, which revealed the program provides targeted health education, male medical exams, group curricula, daily groups with specialized topics, and a male healthy relationships bundle, to include Young Men's Work and Teen Relationships, and discussions of lesbian, gay, bisexual, transgender and intersex (LGBTI) specific groups for our 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 had a written policy and procedures to determine how alerts are identified, documented, updated, and communicated to staff. The program's alerts were consistent with the alerts which were entered into the Department's Juvenile Justice Information System (JJIS). A check with each of the team members reviewing case management, medical, mental health, and safety and security for youth's with identified alert risks, no noted issues. A review of seven youth records conducted for consistency between the program's internal alerts and alerts entered into JJIS found there were no noted issues. Each youth had an identified alert type and the name/title of staff removing/updating alert. In addition when applicable, there was documentation in the program's logbook/shift report supporting alerts was identified and communicated. There was corresponding JJIS alert start and end dates when necessary. Each of the alerts were verified prior to entering into JJIS. Each of the alerts matched in JJIS and the program's internal alert system.

Seven staff were interviewed on how each are informed of the youth's alerts including mental health, medical, and security. Staff responses provided a view into the practices of how the program communicates youth alerts to staff. Staff stated there is a board in the break room with alerts, staff can contact master control, every department has a copy of youth alerts, supervisory staff communicate youth alerts, youth face sheets JJIS) through email, and shift reports.

The facility administrator was interviewed addressing the program's practices for communicating alerts. The FA indicated the program reviews the tracker and med refusals. These items are discussed during the morning meetings and as needed. General information regarding youth safety needs may be discussed during all campus meetings. 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. The facility also maintains an alert board. All department heads receive internal alert sheets.

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

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

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

The program has a formal process to promote constructive input by youth. The program solicits input from youth through youth advisory boards, treatment teams, "Let's Talk" forms, and youth surveys. Six of the seven interviewed youth stated they have a process to provide input about what happens at the program. One youth stated they do not feel there is something in place. The facility administrator was interviewed concerning the process to solicit youth input at the program and stated, the program utilizes community dorm meetings, daily point card meetings, youth advisory boards, treatment teams, and the program's community advisory board to solicit input from youth about the program. The program also utilize "Let's Talk" forms, youth surveys, and the program's community advisory board to solicit input from youth about the program. The facility utilizes community dorm meetings, youth advisory boards, point card meetings, treatment teams, and our community advisory board to solicit input from youth about the program.

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 has a community advisory board which meets at least ninety to 120 days. A review of sign-in sheets, agendas, and minutes from the advisory board meetings were reviewed and confirmed the program meets at least every ninety days. The facility administrator (FA) actively solicits active involvement from law enforcement, judiciary community, other community partners, business community, school board, faith community, and lesbian, gay, bisexual, transgender and intersex (LGBTI) community. The FA recruits victim advocate and a parent whose child was previously involved in the juvenile justice system. Several attempts were made to contact a board member to determine the level of involvement in program activities; however, no one responded or returned the telephone call.

The FA stated during an interview, the community advisory board is comprised of various individuals which represent a victim advocate, member of local law enforcement, concerned citizen, religious community, etc. The community advisory board meets quarterly around 6:00 p.m. During these meetings, they give program updates, solicit feedback, and invite youth to

participate to provide feedback or express concerns and/or needs. The community advisory board is an advocate for program needs and improvements. An example of implementing improvements from the board is utilizing the board support to furnish the clothing closet for the kids who are released with nothing to wear or those who are in need of clothing for interviews upon release. Board members have also been instrumental in providing resources and materials which are needed for the youth in the program.

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

Youth and parent/guardian surveys were reviewed for program planning which are provided as part of the admission process. The comprehensive accountability report (CAR) is a published report related to the program which is generated by the Department of Juvenile Justice, annually. Surveys and reports are incorporated into program planning process and the results are disseminated to staff through all campus meetings. Agenda items to be discussed reflected those areas of input specifically from surveys and reports generated for program planning purposes. A review of sign-in sheets demonstrated staff appear to be in attendance to all campus meetings monthly. The facility administrator (FA) ensures provisions for staffing to include at a minimum a system of communication to keep staff informed and give opportunities to provide input and feedback pertaining to operation of the program. In addition, staff retention planning includes steps to minimize turnover and improve employee morale which is addressed in the program's written policy and procedures. The program's actual practice taken to minimize staff turnover was reflected in contractual amendment for staffing retention bonuses. A review of the program's policy and procedures was completed and determined the program has a system of staff communication, opportunities for providing input, and feedback on the program's operations. A review of minutes and agendas from staff meetings revealed staff are provided opportunities to discuss program planning initiatives. A review of sign-in sheets demonstrated staff appear to be in attendance to all campus meetings monthly where program planning items are provided. Currently the program has four youth care workers, one master control operator, one case manager, and two therapist vacancies. Management meetings are held daily, Monday through Friday with department heads and supervisors. Staff meetings are held monthly with all staff at the program.

Seven staff were interviewed and each confirmed staff meetings are held monthly. In addition, some staff stated meetings are conducted daily and bi-weekly. Several items and/or concerns are addressed and discussed during meetings/briefings. Two of seven staff agreed they are briefed on annual reports and/or youth and parent/guardian survey results. The remaining five staff did not agree they are informed and explained why. One staff stated the surveys are provided to case managers and discussed in the dorm meetings and annual reports are discussed at the monthly meeting. The supervisors are briefed on any Department visitors and on the details of the meeting and/or review. Another staff replied, they are told about the reports and recall having to complete a survey and the youth having to complete a survey. One staff did not provide an explanation. The remaining two staff reported surveys are discussed on what areas need improvement. Surveys do not necessarily trickle down and staff reported they do not deal with case management topics. The seven staff varied in responses pertaining how effective they believed communication is amongst the staff at the program. One staff stated very good, three stated good, one stated fair, one stated poor, and one very poor. A follow-up to how staff believed the effectiveness of communication at the program also varied. When it comes to explaining staff's ability to provide input and feedback into the facility operations, all seven staff had favorable responses, where they are able to provide input.

An interview with the FA provided input concerning program planning practices, addressing morale. The program has reinstituted employee recognition events through employee of the month awards, positive platinum card drawings, blue chip recognition drawings recognizing birthdays, and working hand in hand with human resources and the training department to establish creative ways to recruit and bring new staff onboard. The program held open interviews for all of our vacancies. In addition, there were some turnovers with case managers, administration, and some youth care workers. While vacancies are down, ongoing recruiting efforts are in place to fill vacancies on a continuous basis. Annual youth and staff surveys, Central Communications Center reports, Protective Action Response reports, trackers, educational grade, and general equivalency diploma assessments are all used to track program outcome data. The information from these reports are shared on a regular basis with staff and utilized to set department goals. The CAR report is posted on the bulletin board in administration making it available for all staff to review. The facility conducts a daily morning meeting, shift debriefings on every shift every day, weekly department meetings, monthly all campus meetings, and boards to keep all staff abreast of changes or pertinent information .

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 policy and procedures for determining the program's system for evaluating staff, performance standards, and frequency of evaluations. A review of five sample job/position descriptions demonstrated staff member's performance standards are clearly identified. The five reviewed sample performance evaluations demonstrated they are completed as outlined in the policy, annually. Staff are evaluated annually on established performance standards. Performance standards matched job descriptions for the sample staff reviewed. Key personnel as outlined within the program's contract are being maintained and performed as outlined. Seven staff were interviewed on the frequency for receiving a formal evaluation of their performance. Two staff reported yearly, one staff reported every six months, two staff reported monthly, three staff reported quarterly, and one staff stated they received a performance evaluation almost three times since they have been hired at the program. The facility administrator was interviewed and was able to explain the annual evaluation process for staff. Staff receives an annual performance evaluation scoring on a scale of zero to three. The supervisor has the opportunity to set three goals for their direct reports.

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

The program's activity schedule was reviewed for recreation and leisure activities. The activity schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth. A review of the logbook demonstrated the activities are documented according to the program's activity schedule. The program has written policy and procedures which provide activities based on the developmental levels and needs of the youth in the program. Activities include a choice of leisure and recreation options. Youth are encouraged by staff and activity options to explore interest. Youth were observed to be engaged in constructive use of leisure time. Activities promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program takes precautionary measures to prevent over-exertion, heat stress, dehydration, frostbite,

hypothermia, and exacerbation of existing illness or physical injury. The program's contract includes two recreational therapist positions. A review of the program's staffing roster as well as the therapist's credentials, schedule, and services provided to youth demonstrate all requirements are being met. A review of seven youth case management records demonstrated the therapeutic activities provided is part of each youth's performance plan. The program has a formal process to promote constructive input by youth.

Seven youth were interviewed and each agreed there are large muscle, physical, and leisure activities provided for at least one hour daily. The youth were able to describe some of the activities such as basketball, play station, cards, dominoes, maintenance, Home Builders, books, board games, and football. Each of the seven youth also affirmed they are provided with varying degree of mental and physical exertion throughout the day. Seven staff were interviewed and each were able to provide an example of the time and the types of indoor and outdoor activities provided to the youth.

Standard 2: Assessment and Performance Plan

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

The program has a written policy and procedures for notifying the parent/guardian and court in writing and telephone on the day of the youth's admission. Seven youth case management records were reviewed and each record reflected the program notified the parent/guardian on the day of admission via telephone and in writing.

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

The program has a written policy and procedures to provide each youth orientation to begin on the day of admission. Seven youth case management records were reviewed and each had an orientation checklist which is completed upon admission. The orientation includes services available, daily schedule, expectations and responsibilities of youth, the behavior management system, grievance procedures, availability and access to medical and mental health services, access to the Florida Abuse Hotline or the Central Communications Center, items considered contraband, the performance planning process, dress code and hygiene practices, procedures regarding visitation, mail, use of the telephone, expectations for release from the program, community access, emergency procedures, physical design of the facility, and room assignment. The program did not have a youth admission to observe during the annual compliance review. Seven youth interviews confirmed the youth are receiving orientation on the day of admission to the program.

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

The program has a written policy and procedures in place which addresses consent for youth eighteen years of age or older. Three youth case management records reviewed were applicable for youth being eighteen years of age or older. All three records contained a signed written consent allowing program staff to provide information regarding the youth's physical and mental health screening, assessment, and treatment to their parent/guardian.

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

The program has a written policy and procedures in place addressing the classification process. It is designed to promote safety and security and to implement an effective delivery of services. All seven reviewed youth case management records included the initial classification for each youth which considered the physical characteristics, age, maturity level, special needs such as medical, mental health development, or intellectual and physical disabilities, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization. The classification also identified suspected risk for suicide, medical, escape, and security related issues. All were classified for the purposes of assigning youth to a living area, dorm, group, and case manager. Reassessments were completed prior to considering an increase in the youth's freedom and participation in work projects or other activities. The facility administrator was interviewed and stated these factors are examined and taken into consideration during the pre-classification process and help with setting goals for the youth. The program has a continually updated internal alert system which is easily accessible and visible to program staff and keeps them alerted about youth who have safety and security risks, suicide and mental health risks, medical issues, and assaultive or violent behavior.

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 the seven youth case management records were identified as gang members or affiliated gang members. Law enforcement within each youths' home county as well as local law enforcement, were notified of youth gang involvement on all three applicable youth. The program staff, assigned juvenile probation officer, and educational provider were notified of the youth's gang status.

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

The program has a written policy and procedures addressing gang prevention and intervention strategies. Three of seven youth case management records reviewed were applicable for youth having been identified as a gang member or suspected gang member. All three youth had performance plans with a goal related to gang intervention. The program also utilizes Impact of

Crime (IOC) curriculum as a gang prevention strategy. All three reviewed youth were participating in gang prevention and intervention strategies.

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. All had the Residential Assessment for Youth (RAY) assessment completed within thirty days of admission. Each of the RAY assessments and re-assessment completed were appropriately maintained in the Juvenile Justice Information System (JJIS). One RAY re-assessment was not completed within ninety-days of the initial RAY. It was five days late. All assessments and re-assessments are maintained in the youth's official case management record.

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

Seven youth case management records were reviewed. Six of seven contained a Youth Needs Assessment Summary (YNAS) completed within thirty days of admission to the program. One YNAS was completed thirty-five days late. All seven YNAS were maintained in the youth's corresponding case management record.

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

Seven youth case management records were reviewed. Six of seven contained performance plans which were completed within thirty days of the youth's admission. One plan was sixteen days late. All seven plans were developed after the initial assessment. Each performance plan included specific delinquency interventions, individualized goals, and target dates for completion. All seven plans addressed the top three criminogenic needs of the youth and

contained specific delinquency interventions with measurable outcomes for decreasing criminogenic risk factors and promote strengths, skills, and supports which will reduce the likelihood of the youth reoffending. The plans also contained the youth's responsibility and program's responsibility to enable the youth to complete the goals. The performance plans were all signed by the youth, treatment team leader, and all parties who have significant responsibility in goal completion. Six of seven records contained documentation of the performance plans being mailed to the committing court, juvenile probation officer (JPO) and parent/guardian within ten working days of the plan completion. One was sixteen days late in sending the plan to the JPO. None of the records were applicable for requiring transition activities targeted for the last sixty days of the youth's anticipated stay. Seven interviewed youth confirmed they participated in the development of the performance plan and were able to acknowledge their current performance plan goals. One youth stated they did not receive a copy of their performance plan.

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

Seven youth case management records were reviewed for performance plan revisions. Two plans were updated before the required ninety-day summary due to the original plans not including gang intervention strategies. None of the performance plans were updated before the required ninety-day summary due to new information, progress, and lack of progress toward completing a goal. Three records had revisions due to transition activities during the last sixty days of 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.*	

Three youth case management records were applicable for performance summaries and transmittals. Each had reassessments completed every ninety days following the signing of the performance plan. All three were applicable for requiring performance summaries and transmittals. All were updated within ninety days and had a performance plan completed prior to the youth's release or discharge. In all applicable records, the youth's status on each performance goal and the youth's overall progress on the treatment plan was completed. Three applicable records had documentation of the youth's academic status. The youth's behavior, level of motivation, and interaction with peers were included in all applicable records reviewed. The summaries included the interaction with staff, overall behavior adjustment, and significant positive and negative events. The justification for release or discharge was in all three summaries. Performance transmittals indicated the youth could read and add comments before signing. Each youth was provided a copy of the summary and the original was filed in the youth's case management record. The summaries were signed by the treatment team leader, staff member preparing the summary, program director or designee, and youth. A copy of the

summary was sent to the committing court and the youth's juvenile probation officer (JPO). In all three records, there was no documentation indicating the parent/guardian was sent a copy of the summary but ten days had not yet passed since the summary was completed which this was not applicable. In all three applicable records reviewed, the original summary along with justification for release was sent with the Pre-Release Notification (PRN) to the JPO. Two of the three records had the PRN submitted forty-five days prior to planned release. One PRN was sent to the JPO two days late. A signed copy of the PRN was retained in each of the reviewed applicable youth case management records. The committing court did not indicate objection to any of the reviewed youth PRN's. The program provided written notification to the parent/guardian. All three records had a completed exit Residential Assessment for Youth (RAY). There were no sexually violent predator cases. There was one applicable victim notification letter sent as required. Four of the six interviewed youth reported they received a copy of the completed performance summary once sent to the court.

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

A review of seven youth case management records contained documentation of the program's efforts to include each youth's parent/guardian in the case management process including the initial assessment, development of the performance plan, progress reviews, and formal treatment teams. There were no treatment teams to observe during the annual compliance review. It appears the program encourages involvement of the parent/guardian in the youth's case management process. The parent/guardian is able to participate in person or by telephone in the assessment process, development of youth's performance plan, and formal treatment teams. The parent/guardian has advanced notice of meeting times and dates and can participate by telephone or provide written input. A review of the provider's contractual agreement confirmed the performance expectations are being met. The program also provides family days to perform treatment teams. Letters are mailed out and telephone calls are made to families to encourage involvement. The facility administrator was interviewed and stated parent/guardians are called during pre-classification and given an overview of the program and are introduced to their child's therapist and case manager. The parent/guardian will receive a formal letter explaining the information which is shared during pre-classification. Parent/guardians are encouraged to participate in treatment teams, weekly telephone calls, write and send letters, family days, and family counseling. All seven interviewed youth indicated their parent/guardian was involved in their treatment team and case management process.

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.	

Seven youth case management records were reviewed. In all cases, the program's treatment team members consisted of a treatment team leader, a youth, administration representative, living unit representative, treatment staff, educational staff, Department of Children and Families (DCF) 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 there were no other required parties for participation in the treatment team process.

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.	

Seven youth case management records were reviewed. All seven records contained an academic plan. The youth's academic plan was incorporated into the performance plan. In addition, all seven records incorporated a treatment plan referencing either a concern for mental health or substance abuse treatment into the performance plan. One foster care youth had a support plan through the Department of Children and Families (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. In all cases, the juvenile probation officer (JPO) and the parent/guardian were invited to participate in the reviews. Formal and informal reviews were held biweekly in all seven records. Formal reviews are documented in the seven youth case management records and included the youth's name and the date of the review. Documentation reviewed found all required attendees participated in formal reviews for all seven records. The reviews contained comments from treatment team members and others as well as a brief description of the youth's progress. All seven records had progress on the performance plan goals, positive and negative behaviors, and treatment progress. There were no behaviors resulting in physical interventions. All seven youth had the opportunity to demonstrate skills acquired while in the program. The Residential Assessment for Youth (RAY) reassessment results were applicable and documented in one of the seven records. In six of seven records reviewed, informal reviews were completed bi-weekly each month. The informal reviews had the youth's name, the date of the review, meeting attendees, and any comments from treatment team members or others. All seven records reviewed had a brief synopsis of the youth's progress in the program. All seven records included documentation of the youth progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, and treatment progress. All seven youth had the opportunity to demonstrate skills in the program. The treatment team process was unable to be observed during the annual compliance review. The treatment team documentation was reviewed and the following discussions included the youth's progress on performance plan, positive and negative behaviors, any behaviors in physical interventions, and the youth's treatment team progress. All members actively participated in the meeting and the youth were able to demonstrate the skills acquired in the program. Five of seven youth interviewed stated they were able to demonstrate skills learned in the program.

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

Three of seven youth case management records reviewed were applicable for career education requirements. All three records included evidence of a sample completed employment application, a résumé summarizing education and work experience, a calendar or schedule which identifying an appointment with Career Source Center, and appropriate documents

essential to obtaining employment. All three records had documentation the youth's parent/guardian and juvenile probation officer (JPO) was aware of the vocational plans for the youth. The program's vocational programming is appropriate for the ages of the youth. The career education program is appropriate for the educational abilities and goals, the length of stay, and custody characteristics of the youth in the program. Interviews with the facility administrator (FA) and lead teacher indicated the program offers career vocational services in food management, food handling, Home Builder's Institute (HBI) vocational programming, Career Source, résumé writing, and Florida Ready to Work certification. The program also offers youth cardiopulmonary resuscitation (CPR) and first aid certifications. Career educational services are documented in the youth records and information concerning career education is shared during treatment team meetings, exit staffing, and community re-entry team (CRT) meetings.

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

The program requires youth to participate in educational and career related programs for 250 days of instruction a year. The program utilized ten or less of the 250 days for teacher planning and training. Youth can earn credits for the educational and training experience gained. A review of the program's activity schedule and logbook found evidence of minimal interference of educational instruction. Classes were taking place as scheduled. Five of seven interviewed youth reported there was not a lot of interruptions during school hours. The program's lead teacher reported the educational schedule is weekly from 7:15 a.m. until 2:15 p.m.

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

Seven youth case management records were reviewed for education transition planning. Each record had an individual education transition plan developed based on the youth's post release goals at admission to include all significant personnel related to transition activities, responsibility requirements, and post release needs. Each education and transition plan addressed services and interventions based on each youth's educational needs and post-release plans. The recommended placement for each youth was based on the youth's individual needs and performance. Specific monitoring responsibilities for individuals who are responsible for the reintegration and coordination of the provision of support services were also documented in each record. Three closed records were reviewed for employability as a transition goal and each included provision for continuation of education and/or employment and documentation the youth's case manager and parent/guardian were aware of the plan. In each of the three records, a sample completed application, résumé, a valid Florida Identification, and an appointment with the Career Source Center within the youth's home vicinity were included. Each record indicated the youth's case manager and the parent/guardian were aware of the plan, documents, and post-release discharge plans.

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

Three youth case management records were reviewed for transition planning requirements. All three records had evidence the transition conference was held at least sixty days prior to the youths' targeted release date. All three records indicated the youth, treatment team leader, the youth's juvenile probation officer (JPO), parent/guardian, and educational staff participated in the transition conference. During each of the transition conferences reviewed, documentation confirmed a review of the transition activities and youth's performance plan, identification of transition activities, target completion dates for transition activities, and identification of persons responsible for completion was completed. All three records had evidence the performance plan revisions were completed. The treatment team leader obtained signatures from attendees for all three records. Three applicable records were also reviewed for the Community Re-Entry Team (CRT) meeting. The CRT meeting was conducted prior to the youth's release date in all three cases. The program sends an electronic invitation via email for participation in the meeting.

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

Three youth case management records were reviewed. 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 released. All three records included the transition plan. Included in the exit portfolio were the youth's social security card, birth certificate, vocational certificates earned while in the program, and educational records. All three records had a completed résumé and sample job application. All three records indicated the education staff forwarded the exit portfolio information to the receiving school district. The exit portfolio was verified at the exit conference and the youth was provided a copy upon release in all three records. In addition, the exit portfolio was forwarded to the juvenile probation officer (JPO) in all three records reviewed.

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 youth case management records were reviewed for exit conference documentation and procedure. Two of the three records had an exit conference conducted at least fourteen days prior to the youth's release and the juvenile probation officer (JPO) was notified of the youth's release. All were documented in the youth's case management record to include the date and signatures, names if conducted by telephone, and summary of pending transition goals. All three records had the date of admission and the date of termination documented. Three records included a review of transition activities established at the transition conference. In all three records, the treatment team leader and all other pertinent parties were involved in the exit conference process.

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 full-time psychologist licensed under Chapter 490, F.S. serving as the designated mental health clinician authority (DMHCA) and as the clinical director. The DMHCA is on-site forty hours a week and on call weekends and for all emergencies. The DMHCA is responsible for the oversight of the mental health and substance abuse services at the program. The DMHCA has a clear and active license in the State of Florida expiring on May 31, 2020. A review of the DMHCA written interview indicated a clear understanding of the program's written policy and procedures regarding mental health and substance abuse services.

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

The program has two psychiatrists, one psychologist, and one licensed mental health counselor (LMHC) positions. All clinicians had a clear and active license in the State of Florida. A review of each clinician's scope of licensure, experience, and training indicated the clinicians are working within their scope.

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

The program has five non-licensed clinicians. Each of the five non-licensed clinical staff are master's-level with degrees in a human service related field. All non-licensed clinical staff work under the direct supervision of the designated mental health clinician authority (DMHCA) and assistant clinical director who is a licensed mental health counselor (LMHC). A review of the clinical supervision logs and reports for April 2019 to September 2019, indicated the non-licensed clinical staff received one hour per week of on-site face-to-face direct supervision by the DMHCA or the assistant clinical director. Documentation of direct supervision was recorded

on the provider's forms which have all the Department's required information. The non-licensed substance abuse clinical staff members are employees of a service provider licensed under Chapter 397, Florida Statutes. The five non-licensed clinical staff members have the required twenty-four hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. All non-licensed clinical staff members are qualified to complete assessments of youth for suicide risk.

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

The program has a written policy and procedures for completing the admission/intake mental health and substance abuse screening process. The program utilizes a records review form to document the review of the commitment packet, comprehensive evaluation, face sheet to include alerts, the Community Assessment Tool (CAT), and all other pertinent Department records. A review of seven youth mental health and substance records validated each had a form signed by the therapist and the licensed mental health counselor (LMHC). Each record had documentation a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) was completed at admission and documented in the Department's Juvenile Justice Information System (JJIS). All assessments were completed by a staff member trained to complete the MAYSI-2. All youth admitted in the program are screened using the Assessment of Suicide Risk (ASR) on the day of admission and are seen for a comprehensive evaluation within thirty days of admission. A review of seven youth mental health and substance abuse records confirmed each youth received an ASR on the day of their admission. The program also completes screenings utilizing the Adolescent Psychopathology Scale (APS), Trauma Symptom Checklist for Children (TSCC), Reynolds Adolescent Depression Scale – Second Edition (RADS-2), Adolescent Substance Abuse Subtle Screening Inventory (SASSI-2), and an assessment for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). A review of seven youth records confirmed the admission practice.

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

The program has a written policy and procedures describing the comprehensive plan for mental health and substance abuse services. Seven youth mental health and substance abuse records were reviewed. Each had documentation of referral for mental health and substance abuse assessments and evaluations. The program completed seven new assessments. The assessments included all the required elements. The seven assessments were completed by a non-licensed clinician and reviewed by a licensed therapist. All assessments were reviewed within the ten-day time frame. The seven records had the required consent forms signed.

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

The program has a written policy and procedures for providing treatment services. Seven youth mental health and substance abuse records were reviewed and each indicated a need for mental health and substance abuse treatment. All youth were assigned to a multidisciplinary treatment team during the intake process. The multidisciplinary treatment team consisted of a residential living unit representative, the parent/guardian, education representative, administration staff representative, substance abuse/mental health staff, and medical staff. A review of seven youth mental health and substance abuse records reflected the program provided mental health and substance abuse evaluations and groups, treatment planning, daily group therapy, monthly individual and family therapy, support services, substance abuse therapeutic activities, psychiatric services, suicide prevention services, and individualized transition services. Staff interviews indicated the therapists conduct clinical groups. The seven youth records indicated individual, group, and family counseling were provided in accordance with each youth's initial and individualized mental health and substance abuse treatment plans. Reviewed documentation of mental health groups indicated the groups were limited to ten or fewer youth and substance abuse groups were limited to fifteen or fewer youth. The mental health and substance abuse services are provided by the licensed mental health professional (LMHP) and/or the five non-licensed mental health clinical staff working under the direct supervision of the licensed mental health professional. The DMHCA written interview and informal interview with the assistant clinical director acknowledged the program’s treatment services. The program’s treatment services also include Impact of Crime (IOC) and Living in Balancing (LIB) groups.

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

The program has a written policy and procedures for treatment and discharge planning. Seven youth mental health and substance abuse records were reviewed. Each contained an initial treatment plan completed on the Department’s Mental Health and Substance Abuse (MHSA) form . The plans had the required elements and were signed within seven days of treatment by the licensed MHSA clinical staff. The seven initial treatment plans included the youth’s psychiatric needs. Six youth records indicated continuation of prescribed psychotropic

medication. The six youth taking psychotropic medications initial treatment plans contained documentation of the psychiatrist monitoring the prescribed psychotropic medication and the frequency of the monitoring. Initial treatment notes were completed and signed by the licensed MHSA clinical staff. All seven youth records contained an individual MHSA treatment plan which were signed by the licensed MHSA clinical staff. The seven individual MHSA treatment plans contained the required elements of the Department's MHSA form 016. Three closed youth MHSA records were reviewed. The three discharge plans were completed on the program's form which contained all the elements on the Department's MHSA form 011. None of the closed youth records indicated a suicide risk alert or notification of suicide to the parent/guardian. The three discharge plans contained services needed for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by youth during treatment. The closed records documentation indicated the discharge plans were discussed with the youth, the parent/guardian, and the juvenile probation officer (JPO) during the exit conference. Documentation in the closed records indicated the MHSA treatment discharge summary provided to the youth, the youth's JPO, and the parent/guardian.

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's treatment services are provided in accordance with Florida Statutes, Administrative Rule, and the provider's contract. The program provides specialized mental health services and substance abuse overlay services (SAOS). The program's specialized mental health and substance abuse treatment services include monthly individual therapy sessions and monthly family therapy sessions. Other services include mental health treatment groups, substance abuse groups are provided seven days a week to include group process therapy, anger management groups, conflict resolution, clinical education group forums, and other psycho-educational training groups. Supportive counseling is provided as-needed. The specialized mental health treatment services are provided by qualified clinicians.

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

The program has a written policy and procedures for providing psychiatric services. Psychiatric services are provided by two contracted independent licensed psychiatrists. The psychiatrists are licensed under Chapter 459. A review of seven youth mental health and substance abuse records indicated six youth entered the program on psychotropic medication. Each initial psychiatric interview included elements specific to the Rule 63N-1 and occurred within fourteen days. Each youth received a psychiatric evaluation within thirty days. Medication monitoring was completed by the psychiatrist every thirty days. A review of the sign-in logs and the treatment team verification meetings indicates the psychiatrics are on-site weekly per the contract. The six youth records had signed Authority for Evaluation and Treatment (AET) forms. None of the youth psychotropic medications were newly prescribed at the program, discontinued at the

program, or had a significate drug dosage change at the program. Each youth's psychiatric evaluation was documented on the Department's Clinical Psychotropic Progress Note (CPPN) and program-specific forms completed as delineated in policy.

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

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

The program has a written policy and procedures to provide suicide prevention services. The program's policy indicates all admissions receive a suicide assessment at intake. Seven current youth and one closed mental health and substance abuse records were reviewed for suicide prevention services. Each youth was placed on precautionary observation at intake. Five of the seven current youth were discontinued on precautionary observation. Two of the seven current youth and the one closed youth record were continued on precautionary observation and placed on constant supervision. An Assessment of Suicide Risk (ASR) was completed in each record. All applicable records documented the juvenile probation officer (JPO) was notified of the youth's potential suicide risk as indicated by the ASR. Three records documented the parent/guardian was notified of the potential suicide risk. Each ASR was completed by a licensed mental health professional (LMHP) or a clinical staff under the supervision of a LMHP. Each ASR documented the facility administrator (FA) or designee along with the licensed mental health staff were consulted prior to changing the youth's supervision level which included

the actual date and time of the consultation. A follow-up ASR was completed for each youth prior to their removal from precautionary observation. During the time the youth were on precautionary observation, the youth could participate in select activities as deemed appropriate and the youth were not restricted to their room. The FA indicated secure observation is not utilized at the program. A review of the Department's Juvenile Justice Information System (JJIS) reflected a suicide alert was initiated for the three youth placed on suicide precautions and the alert was closed once an ASR was completed. The youth were no longer deemed a suicide risk by the mental health professionals. Precautionary observation logs were completed for the duration the youth was on suicide precautions. Each form was completed to include safe housing areas and all observation logs documented checks of the youth at least every thirty minutes. Suicide response kits included the knife-for-life, wire cutters, and needle nose pliers are maintained in the modules where youth are currently housed and in master control. The facility logbooks were reviewed for documentation of suicide precautions and removal of such supervision. The facility logbook documented the youth were transitioned to close supervision and then to standard supervision upon the completion of close supervision. Seven interviewed staff identified the location of the suicide response kits. Each staff stated if a youth expressed suicide thoughts the youth and room are searched for sharp objects, the staff must maintain constant sight and sound supervision, and the staff must document the supervision of the youth. The interviewed staff stated they notify the shift supervisors and the mental health staff when a youth expressed suicide thoughts. The program also has a written policy, procedures and practice in the event of a serious suicide attempt or serious self-inflicted injury, or a mortality incident initiated by the multidisciplinary review team which includes the circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, and pertinent medical and mental services involving the victim.

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

The program has a written policy and procedures for documenting suicide precaution observations. Seven current and one closed youth mental health and substance abuse records were reviewed for suicide prevention services and documenting suicide prevention observations. Five of the seven current youth were discontinued on precautionary after the admission process. Three youth mental health and substance abuse records were applicable for suicide precaution observation logs. Two of the seven current youth and the one closed record were continued on precautionary observation and placed on constant supervision. Each record contained documentation of suicide precaution logs being maintained for the duration the youth was on suicide precautions. Each log documented observations of the youth's behavior and checks of the youth at least every thirty minutes. Each suicide precaution log was signed by a shift supervisor and a licensed mental health clinical staff member. Each suicide precaution log documented safe housing requirements. Three youth were transitioned from constant supervision to close supervision. A visual check log was maintained for each youth for the duration they were on close supervision. The facility administrator stated secure observation is not utilized at the program. Five youth placed on suicide precaution stated staff was always with them and never left alone for any period.

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

The program has a written policy requiring all staff to be trained on suicide prevention. Seven staff training records were reviewed for in-service training and all seven staff training records had documentation of six hours of suicide prevention training. All fourteen staff training records had documentation of four hours of instructor-led training and two hours of suicide prevention training through the Department's Learning Management System (SkillPro). The program completed monthly suicide and mental health drills. A suicide drill or a mental health drill was conducted monthly on each shift. The drills included the use of the 9-1-1 system, suicide kits, and cardiopulmonary resuscitation (CPR). There were sixty-one staff applicable for suicide drills. Sixty-one staff participated in at least one suicide drill during the past six months.

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

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

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

The program has a written policy and procedures in place to conduct crisis assessments. A review of the crisis assessment forms denotes all the required elements. The program reported there were no crisis assessments completed during the review period and none in the past twelve months.

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 policy and procedures for emergency mental health and substance abuse plan. The plan components include immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statutes (Marchman Act), documentation, training, and review. The plan was reviewed, updated, and signed by the facility administrator (FA) and the DMHCA on February 13, 2019.

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

The program has a written policy and procedures for Baker Acts and Marchman Acts. The program did not utilize a Baker Acts or Marchman Acts during this review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

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

The program has a written policy and procedures addressing the position of designated health authority (DHA). The program's DHA is a licensed osteopathic physician who holds an unrestricted clear and active license with an expiration date of March 31, 2020. The physician's specialty is in the field of family practice. The program does not employee a physician assistant or advanced registered nurse practitioner; therefore, the program does not require a Collaborative Practice Protocol. A review of the provider's contract found the DHA is required to be on-site at least once per week for a total average of seven hours weekly. The sign-in and sign-out logs for the DHA were reviewed from the previous six months to confirm the consistency with this practice. The program's DHA is responsible for communication with program staff regarding youth medical needs and has availability for consultation by telephone or electronic means twenty-four hours a day, seven days a week. In the event the DHA is on vacation or has a scheduled absence, coverage is arranged with a physician of equal licensure. The backup physician is required to provide coverage on an as needed basis. This physician holds an unrestricted clear and active license with an expiration date of January 31, 2020. The DHA was interviewed and stated they are on-site every weekday. The DHA stated meeting daily with the nursing staff to discuss youth and any other relevant issues. The DHA confirmed being on-call and available twenty-four hours a day, seven days a week. The DHA performs Comprehensive Physical Assessments on all newly admitted youth and again if the youth are at the program for over a year. The DHA sees youth for renewal of medication for chronic conditions as well as health complaints which need to be addressed by a doctor. In addition, the works with the nursing, clinical, and management staff to develop any needed policies and procedures.

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.	

A review of the program's written operating procedures and treatment protocols was completed. The program's designated health authority (DHA) and licensed psychiatrist signs all respective protocols and policies. Observations made also found nursing staff signs and dates a cover page on which all policies and protocols are written which indicates a review of the information. An interview with the program's health services administrator (HSA) revealed the program has not hired any new nurses for the scope of the annual compliance review. The HSA stated all newly hired medical staff will review the policies and protocols as part of their orientation packet.

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

Seven youth individual healthcare records (IHCRs) were reviewed for the Authority for Evaluation and Treatment (AET) documentation. Six IHCHs contained either an original AET or a legible copy with the word "copy" stamped on the AET. The remaining one record contained

evidence the youth was eighteen years of age upon admission and signed documentation indicating the youth did not desire any notifications concerning the youth to be sent to individuals outside the program. Copies of all notifications are maintained behind the AET section of each IHCR. None of the records reviewed had evidence the youth were in the care of the Department of Children and Families (DCF) where there has been a termination of parental rights. The health services administrator (HSA) was interviewed and reported all projected new intakes are reviewed in the Juvenile Justice Information System (JJIS) for validation of the AET. If there is not a valid AET in JJIS, the HSA contacts the case manager to obtain a valid AET from the assigned juvenile probation officer.

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 notification and consent requirements. All applicable records contained documentation of parental notifications for over-the-counter (OTC) medications beyond those covered by the Authority for Evaluation and Treatment (AET). One record was applicable for and contained, documentation for vaccinations and immunizations not consented for on the AET. Three applicable records had documentation of a discontinuation of medication prescribed prior to the youth entering the custody of the Department. Two applicable records had documentation of parental notifications for off-site emergency care and changes in medication for youth with chronic conditions. Five applicable records had evidence the parent/guardian was notified when the youth were taken off-site for routine dental treatment or appointments. For new medications verbal attempts were documented in the progress notes for four applicable records. Written notifications were observed and a staff member signed indicating as a witness for all call attempts and conversations. Three applicable records had documentation of notification when a psychotropic medication was initially prescribed, discontinued, or changed. The parent/guardian verbal consent was documented through page three of the Clinical Psychotropic Progress Note (CPPN). Written consent was also documented on the Acknowledgement of Receipt (AOR) of the CPPN. The letters were mailed with a request for return. Only one of three was returned signed by the parent/guardian. All seven reviewed IHCRs contained evidence vaccinations were verified within thirty days of each of the youths' admission. None of the reviewed records required religious exemption from immunization. The health services administrator (HSA) indicated if exemption is for religious reasons the parent/guardian is directed to the local county health department to complete the appropriate form filed with the health department and a copy provided to the facility to be filed in the youth's IHCR in the immunization section. If the exemption is for medical reasons, the parent/guardian shall provide a copy of the medical exemption signed by the youth's physician. This form is then filed in the youth's IHCR in the immunization section. The HSA indicated immunizations are obtained prior to the youth's admission.

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.	

Seven youth individual healthcare records were reviewed for completion requirements of the Facility Entry Physical Health Screening (FEPHS) form. All seven records contained an FEPHS completed on the day of the youths' admission. All were completed by a registered nurse (RN).

None of the records were applicable for and required completion of a new FEPHS due to a change in physical custody.

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.	

Seven youth individual healthcare records (IHCRs) were reviewed for youth orientation for health services and health education. All seven IHCRs contained evidence each youth received general care orientation upon their admission to the program. Topics discussed in the healthcare orientation include access to medical care, sick call process, what constitutes an emergency, medication process, the right to refuse care, what to do in the event of a sexual assault, and the non-disciplinary role of health care providers. All healthcare education completed was signed by the youth and filed in the health education section of the youth's IHCR. The program utilizes the Department's required Health Education form for health education documentation of topics presented.

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

The program's health services administrator (HSA) stated the designated health authority (DHA) is notified and referred for each new admission. All seven youth IHCRs contained evidence of telephonic notification to the DHA upon the youth's admission. None of the youth were in need of an emergency response at the time of admission. The notification was found in the chronological progress notes on the youth's IHCR.

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. All seven IHCRs contained a completed Health Related History (HRH, which was completed at the time of the youths' admission to the program. Each was completed by a registered nurse (RN). The form also contained evidence the designated health authority (DHA) reviewed and signed the HRH. Each HRH was completed prior to the completion of the Comprehensive Physical Assessment. An interview with the health services administrator (HSA) confirmed the HRH is completed by the nurse on duty during the initial youth intake. The HRH is updated by medical staff for any significant medical event or change. All forms are reviewed by a nurse annually, as needed.

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.	

Seven youth individual healthcare records (IHCRs) were reviewed for completion requirements of the Comprehensive Physical Assessment (CPA). The program utilizes the Department's CPA form. All seven IHCRs contained a CPA completed within seven days of the youths' admission. The program's medical doctor who serves as the designated health authority (DHA) completed

all seven CPAs reviewed. The accurate medical grade was indicated on each CPA. The documentation was completed in accordance with Florida Administrative Rule requirements. All sections of the CPA were observed marked with an ”O”. Parts of the exam which were refused by the youth were observed documented as such. The DHA indicated by writing ”youth declined” beside the appropriate section of the form. In addition, all refusals were documented on refusal forms and located in the youth’s IHCR. For each of the seven records, the Problem List was updated as required. Each youth was assessed prior to placement in general population as the program’s practice for new intakes is to take the youth to medical for all required screenings and assessments. Each of the seven IHCRs contained evidence the results of the tuberculosis screening test (TST) were documented on the CPA as well as the Infectious and Communicable Disease (ICD) forms. The program has a written policy and procedures which addresses completion of the CPA and the medical screening process for newly admitted youth. The policy is in compliance with the Centers for Disease Control and Preventions (CDC) new 2006 recommendations and Occupational Safety and Health Standards (OSHA). An interview with the health services administrator (HSA) indicated the initial CPA is completed within seven days of each youth intake. For each youth, the Juvenile Justice Information System (JJIS) records are reviewed prior to admission to review for Purified Protein Derivative (PPD) status. A tuberculosis screening is completed by the nurse during the intake process. All PPD due dates are maintained in a tracker system and screenings are completed annually.

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.	

Seven youth individual healthcare records (IHCRs) were reviewed for sexually transmitted infection screening (STI) and human immunodeficiency virus (HIV) screening. All seven IHCRs found evidence of screening for STIs. Testing for STIs was ordered and performed for each youth reviewed. Results for screenings were documented on the Infectious and Communicable Diseases (ICD) form and filed in each IHCR. None of the reviewed records had evidence the youth were out of the Department’s physical custody requiring a re-screening. All referrals were observed documented on the STI screening forms. There was evidence in all seven IHCRs indicating the youth were offered counseling, testing, and treatment for HIV. The program completes an HIV Risk Assessment form for all youth as part of their orientation and intake screening. Five applicable IHCRs reviewed had documentation the testing was completed. The remaining two youth documented they refused testing. Documented consent from the youth was obtained in each of the five applicable cases reviewed. Documentation of pre-test and post-test counseling was also indicated in the progress notes section of the IHCR. The program has a certified HIV counselor who conducts the testing and provide the pre-test and post-test counseling. A copy of the 501 certification was reviewed to confirm the credentials of the counselor. The testing results were observed filed confidentially in a sealed envelope marked “confidential”. The program does not document the youths’ HIV status within the internal alert system. Seven interviewed youth all reported they were able to request an HIV test if they chose.

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.	

Seven youth individual healthcare records (IHCRs) were reviewed. Three records were applicable for youth having completed sick call complaints. None of the three applicable records had evidence the youth presented similar sick call complaints three or more times within a two-week period. None of the complaints were of severe pain of which staff were unfamiliar. Each IHCR contained the completed Sick Call Request form with the progress notes in reverse chronological order. The program's nursing staff is comprised only of registered nurses (RNs). Nursing services are available twenty-four hours a day at the program. Each of the three IHCRs reviewed had documentation the RN conducted the sick call. Based on the records reviewed, there were no reported instances of youth who were in restricted housing of any kind. Sick Call Request forms were observed available in program areas and youth living areas. A locked drop box was located with the Sick Call Request forms for youth to complete the form and drop it in the locked box. The medical staff checks the boxes daily. Sick call forms and progress notes are documented in accordance with Health Services Rule. All sick calls were observed documented in the Sick Call Index and the Sick Call Referral Log. Sick call hours were observed posted and visible for staff and peers. Sick call is provided seven days a week, from 9:00a.m and 1:00p.m. Sick calls are conducted in the medical office area. An actual sick call was unable to be observed during the annual compliance review. However, observations were made of the sick call room which included an exam table within a private area to maintain youth confidentiality. Seven staff were interviewed and each stated the nurse responds to sick calls for youth. Four of seven interviewed youth reported they can see the nurse within one day from putting in a sick call request. The remaining three youth reported they have never filed a sick call request.

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

The program has a written policy and procedures addressing episodic and emergency care process. Emergency medical and dental services are available twenty-four hours daily. Seven youth individual healthcare records (IHCRs) were reviewed for episodic, first aid, or emergency care. Five of the seven IHCRs had evidence the youth required on-site first aid or episodic care. All healthcare was provided for by a registered nurse (RN). For each incident, the documentation recorded included the date and time of the care, nature of the complaint, any over-the-counter (OTC) medications given if applicable, treatment provided, and education and instructions for the youth. None of the incidents required youth to be placed on an internal alert list. None required a referral for off-cite care or parental notification. For each IHCR, the licensed healthcare staff documented in problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Suicide response kits and first aid kits are available throughout program areas and within youth living areas. The program has a total of eleven first aid kits found throughout designated areas. A review of three kits found all items within matched the inventory listing provided inside. The kits were fully stocked with approved contents. The medical staff checks all first aid kits weekly. The program has one automated external defibrillator (AED) which is located in the medical department. The instruction guide is located with the device. The RN is responsible for ensuring the AED batteries and pads are operable.

The RN demonstrated a check of the device during the annual compliance review. The AED batteries had an expiration date of May 2022. The pads had an expiration of May 2020. Copies of all checks were made for the scope of the annual compliance review to confirm the practice of inspecting the device. In addition, medical drills are conducted monthly for all three program shifts. The frequency of the drills is also indicated within the program's written policy and procedures. A review of the drills for the previous six months found no exceptions. Drills were completed monthly on all shifts. Drills also included a demonstration of cardiopulmonary resuscitation (CPR), first aid, and AED. An interview with the health services administrator (HSA) revealed the program does not train non-healthcare staff on the administration of the epinephrine auto-injector, as the program employs a nursing staff twenty-four hours each day. Five of the seven interviewed staff indicated they could call 9-1-1 in the event of an emergency. Two staff indicated they were not certain. Six of seven interviewed youth reported they are able to see a dentist if needed. All seven youth reported they can see a doctor if 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 referrals of emergent and non-emergent incidents. Two IHCRs were applicable for youth requiring off-site emergency care. Five IHCRs were applicable for youth requiring non-emergent care through dental services. In all IHCRs, there was documentation of parental notification and the Summary of Off-Site Care form was utilized and filed within the IHCR. Six applicable IHCRs had discharge documentation filed. The designated health authority (DHA) initialed all off-site care findings. Three applicable youth required follow-up testing or appointments. There was evidence referrals were tracked for the three applicable youth. The youth received appropriate timely follow-up care as needed.

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.	

Four of seven youth individual healthcare records (IHCR) were reviewed for periodic evaluations for chronic conditions. None were applicable for having a communicable disease. All IHCRs were classified as a medical grade five. Each youth was identified on the Health-Related History form for having a current chronic condition. All applicable youth were placed on a chronic illness list and tracked on a computerized tracking system which is managed by the health services administrator (HSA).There was evidence of a specialized treatment plan and periodic evaluations at no greater than three-month intervals for each IHCR. None of the youth were applicable for taking anti-tuberculosis medication. All periodic evaluations were documented and maintained in the IHCR. The evaluations were conducted prior to renewal of a prescription medication which may expire. All periodic evaluations were conducted on-site and documented in the progress notes. Treatment orders were written so they are clear and distinguishable for medical staff. There were no observed lapses in care or missed periodic evaluations. In each IHCR, the Department's Problem List was updated in accordance with the Health Services Rule. The designated health authority was interviewed and stated most chronic conditions are addressed every two months through periodic evaluations. The nursing staff maintains a tracking system to monitor periodic evaluations.

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.	

Seven youth individual healthcare records were reviewed for medication management requirements. Five of the seven IHCRs were applicable for medication management, as the youth entered the program on prescribed medication. The medication was verified prior to being accepted to the program for the five applicable youth. Prescription verification was documented in the chronological progress notes in each of the five IHCRs utilizing the medication verification checklist. For each youth, the designated health authority (DHA) was contacted to obtain the order to resume the specified medications youth were prescribed prior to admission. All five IHCRs contained a current and valid order. For each IHCR, changes or discontinuations in medications were documented in an order within the Practitioner Order Form and in the progress notes. None of the youth were applicable for restricted housing. Two applicable youth required over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET). These medications were administered according to the practitioner's order. The program utilized the pre-printed pharmacy Medication Administration Record (MAR) which includes all information required in Florida Administrative Rule, for the five applicable youth who entered the program on prescribed medication., The medical staff initial each administered medication entry. The program does not authorize non-healthcare staff to administer medication, as they employ nursing staff twenty-four hours a day, seven days a week. A review of five youth MARs found no lapses or errors in medication administration. Documentation of weekly side-effect monitoring was also observed for each youth IHCR. Medication pass is administered twice daily. A medication pass was observed during the annual compliance review and confirmed the Six Rights of Medication Delivery/Administration were maintained as required. Three of the five reviewed MARs contained evidence the youth refused medication on various days. The refusals were clearly marked using a red pen and writing the letter "R" in the corresponding box. Each incident of refusal contained a corresponding and completed Refusal Form behind the MAR in the IHCR. The room used to store medications was observed to be secured and located within the secure medical department office area. All medications were stored in a separate area inaccessible to youth. Controlled medications were stored behind two locks within the medication cart which was also located in the secured room. Oral medications were not stored with topical medications. Some medications which require refrigeration were stored in a secured refrigerator which also had a daily temperature check list posted. All syringes and sharps were secured. The medication cart was clean and organized with stock items stored separately from youth specific medications. The program has a written policy and procedures concerning the disposal of medication. The health services administrator (HSA) was also interviewed to confirm the disposal practice. Any discontinued medications or medications requiring disposal are counted daily. The medications are disposed of using the chemical RX Destroyer. This is completed monthly when needed. The HSA provided documentation of the disposal log to confirm the practice. Controlled medications are destroyed on-site with the pharmacist. Regarding the storing of medications, the HSA stated current medications are stored in the locked med cart. All excess and future medications are stored in locked cabinets in the medical department. All controlled medications are double locked in the med cart and inventoried every shift by the on-coming and out-going nurse. Seven youth were interviewed concerning medication administration. Five stated they receive medication form the nurse and one stated receiving their medication from the doctor. One youth reported they do not take medications. Controlled medications were stored behind two locks within the medication cart

which was also located in the secured room. Some medications which require refrigeration were stored in a secured refrigerator, which also had a daily temperature check list posted.

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

The program maintains all medical equipment including medications within the secured medical department. All medical equipment classified as sharps are secured and inventoried using a perpetual inventory descending count. A review of inventory documentation for the previous six months for over-the-counter (OTC) medications and items considered sharps was completed to confirm the practice. There were no discrepancies identified. All medications were observed secured in locked cabinets or the locked medication cart. Medications such as topicals, liquids, drops, and injectables are all stored separately. The program has a written policy and procedures concerning the disposal of medication. The health services administrator (HSA) was interviewed and confirmed the disposal practice. Discontinued medications or medications requiring disposal are counted daily. The medications are disposed of using the chemical RX Destroyer. This is completed monthly when needed. The HSA provided documentation of the disposal log to confirm the practice. Controlled medications are destroyed on-site with the pharmacist. All medications are inventoried on a shift-to-shift inventory count. Inventories for the previous six months were reviewed to confirm the practice. There were no discrepancies identified. The program employs registered nursing staff twenty-four hours each day, seven days a week. The HSA reported non-healthcare staff do not give out medication to youth. The number of pills, tablets, or dosages remaining after each administered dosage was observed documented on the youth's Individualized Controlled Medication Inventory Record received with the medication from the pharmacy. Observations of inventories for two controlled medications, three sharps, and three OTC medications was made during the annual compliance review. The nurse was seen counting each medication and item and comparing them with the number on the inventory sheet. There were no discrepancies identified. The HSA stated current medications are stored in the locked med cart. All excess and future medications are stored in locked cabinets in the medical department. All controlled medications are double locked in the med cart and inventoried every shift by the on-coming and out-going nurse. An interview with the HSA revealed should a discrepancy occur, the nurse would verify the count number, recount the items, and report the information immediately to the HSA. The program reported there were no reportable incidents involving medication miscounts or discrepancies during the annual compliance review period.

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 an infection control plan and written policy and procedures in place to include the prevention, containment, treatment, and reporting requirements related to infectious diseases per Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control (CDC) guideline. The infection control procedures include all required areas. An interview with the program's human resources manager revealed the on-site medical department does not administer hepatitis B vaccine. The program has an agreement with Med-X which administers the vaccine affording all new hires the opportunity to have this completed off-site. This was documented within the new employee handbook and in a sample of three staff personnel records reviewed. The program's registered nurse conducts a training on universal precautions twice annually in order to ensure each staff receives the training at least one time a year. This is also completed in orientation for all new hires. An interview with the health services administrator (HSA), stated there were no reported incidents this annual compliance review period in which the local county health department, the CDC, and Central Communications Center should have been notified of an infectious disease. In addition, the HSA indicated there were no instances of quarantining or hospitalization of at least ten percent of the total population of youth or staff this review period. The program has a comprehensive process for needle stick exposure. The HSA reported the program has not experienced a facility occupational exposure. The human resources manager stated should this occur; the information would be filed separately within a worker's compensation claim. The program has an exposure control plan which is written in accordance with OSHA standards and is available to all staff. The facility administrator was interviewed and reported the plan is made available in the plant manager's office and the medical department. The plan was observed to be signed annually by the program administration. The plan includes risk assessment and methods of compliance.

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 non-applicable.

Standard 5: Safety and Security

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

The program has a written policy and procedures outlining youth supervision, staffing ratio, and coverage. According to the written policy and procedures, active supervision is defined as the use of effective and efficient supervision which includes positive contact, positive reinforcement, structured activities and random/predictable movement which provides suitable and timely response to the everyday needs of the youth and immediate response to emergencies while maintaining the safety and security of the program. The program's staff to youth ratios are one to eight during awake hours, one to twelve during sleep hours, and one to five for off-site activities, visitation, or when separated from the population. On the first day of the annual compliance review, youth were observed in the classroom, moving between classes, and sweeping in the kitchen after lunch. On the second day of the annual compliance review, youth were observed moving to and from education and five youth were observed going on transport for a routine dental appointment. On the third day of the annual compliance review, youth were observed moving between classes, playing basketball, and assisting maintenance personnel. On the last day of the annual compliance review, youth were observed moving from their living units to the classrooms and changing classes. Staff to youth ratios were observed to be in compliance each day. At random, staff were questioned throughout the annual compliance review on the number of youth they were supervising. Each were able to accurately report the number of youth under their supervision. Positive interactions between staff and youth were observed throughout the annual compliance review. Observation of the program's activity schedule was posted throughout the program to include youth living units and reflected a full schedule of activities. Consistent applicable of the behavior management system (BMS) was observed throughout the annual compliance review. Staff account for youth under their supervision at all times. At no time were youth observed unaccompanied. Staff observed youth while they were sleeping and verified by review of video surveillance. Seven interviewed staff reported if a count cannot be reconciled, a recount is conducted, and if necessary an emergency count is conducted.

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

The program has a written policy and procedures ensuring youth in their care are provided with a safe and therapeutic environment which promotes positive social change while holding youth accountable for their behavior through behavioral expectations and consequences for meeting or not meeting given expectations. The program's behavior management system (BMS) is clearly written and included in the youth handbook. Observation of the BMS was posted

throughout the program to include the youth living units. A review of seven youth records reflected the orientation process includes a review of the youth handbook and BMS. All seven youth records contained an orientation checklist in which both youth and staff sign and date the BMS was reviewed. The rules governing conduct and positive and negative consequences for behaviors were observed 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. The program's clinical staff and recreational therapist were both responsible for the update to the BMS and have appropriate training and experiences in BMS. 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 incorporates the Principles of Effective Behavior Management established by the Department of Juvenile Justice. The program's BMS offers a variety of rewards and/or incentives. Seven staff interviews were familiar with the program's BMS. Seven interviewed staff reported youth receive snacks, games, music, parties, point store, off campus activities, television, and movies as rewards. Four of seven staff reported extra incentives items such as crayons, pencils, television, cards, and their risk level can be taken away as a consequence. Three of seven staff reported nothing can be taken away as a consequence. Seven interviewed youth were familiar with the BMS. Two of seven youth reported consequences are not fairly given out. Five reported consequences were fair. Seven interviewed youth reported the following types of consequences includes loss of incentives such as television and games, loss of points, and special treatment team meetings. Seven interviewed youth i reported receiving longer phone time, staying up later, snacks, games, video games, and point store rewards. The facility administrator (FA) reported the program uses the Positive Performance System (PPS) which has levels of which youth earn different incentives and program activities through earned days. Additionally, the FA reported the system is driven by treatment progress as evidenced by daily earned days, incentives, and treatment team progressions.

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

The program's written policy and procedures outlines a protocol in which staff is provided feedback regarding their implementation of the behavior management system (BMS). A sample position description for a youth care worker (YCW) was available for review. The sample included the required qualifications for implementation of the BMS. The provider's contract included all required parties were involved in the development, implementation, and ongoing maintenance of the BMS. The program does not use room restrictions. The BMS allows staff to

explain the reason for any sanction imposed on a youth and the youth is given an opportunity to explain their behavior. The BMS does not include: increased length of stay, denial of basic youth rights, promotion of group punishment, punishment by other youth, or disciplinary confinement. Fourteen staff training records (seven in-service and seven pre-service) were reviewed for BMS training in which documentation reflected staff received pre-service and in-service BMS training. Staff are trained in the jointly combined BMS plan to include the use of BMS during school. Seven of seven youth interviewed were familiar with the BMS. Seven of seven staff interviewed were familiar with the BMS. Seven of seven staff reported youth are informed of their consequences and are given an opportunity to explain their behaviors. Seven of seven staff reported they are given feedback in regards to their use of the BMS. Seven of seven youth reported youth are not allowed to punish other youth. Three of seven youth reported staff are not consistent in giving rewards, four reported staff were consistent. Five youth reported the BMS was fair, one reported it was good, and one reported the BMS was very good. The facility administrator reported the recreation therapist tracks the weekly points and use of the BMS. In addition, consequences are reviewed at morning management meetings.

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

The program has a total of one hundred ninety-two cameras in which one hundred ninety are operational. Video footage is stored for thirty days. The program has three shifts A, B, and C and two dorms comprised of four youth living units, Alpha one and two and Bravo one and two. Historical video footage was reviewed on the September 9, 27, and 28, 2019 for Alpha One, Alpha Two, and Bravo One dorms. All checks during these time frames were observed to be completed as required and as documented by staff. Staff were observed walking to the doors of each youth room and looking in the window. Historical video footage was also observed on two separate days for Bravo One and Alpha Two dorms on September 24, 2019 during the A shift and on September 28, 2019 during the C shift for the time periods of 6:16 a.m. through 6:30 a.m. and 1:14 a.m. through 1:32 a.m. No checks were observed being completed during these times as documented by staff which resulted in the program reporting falsification to the Central Communications Center (CCC). Additionally, the program maintains an Accountability Review binder for ten-minute checks. A review of this binder reflected checks not being completed as documented on five different occasions over the previous six months, this information was included in the CCC report made during the annual compliance review. Seven interviewed reported checks are conducted every eight minutes during sleeping hours or non-punishment reasons.

5.05 Census, Counts, and Tracking	Satisfactory Compliance
The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day. *The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.* *The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is 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 ensuring an effective means for population counts and youth supervision to determine and accurately document the total number and location for youth at all times. According to the written policy and procedures, at least six formal counts within a twenty-four-hour period will be conducted. The six formal counts coincide with the times for counts at the beginning and ending of each shift. The program documents formal counts as well as counts being conducted after each outdoor activity and during emergency situations in the logbook. The program also documents total daily census counts, youth movements, new admissions, releases, and when youth are temporarily away from the program. Count documentation is highlighted in yellow in the program's logbook. Seven interviewed staff were familiar with count times and what to do in the event of a discrepancy in count.

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

The program has a written policy and procedures for a daily account of routine and emergency situations involving youth through the use of logbooks. Logbooks were observed to be bound with numbered pages, not falling apart, or missing any pages. Entries were made with black ink with no erasure or white out areas. No logbook entries were observed to be obliterated or removed. Any errors were observed to be struck through with a single line and dated and initialed by the person correcting the error. Observation of each entry included the date and time of event, the name of the staff and youth involved, a brief description of the event, and the name and signature of the staff member making the entry. The program documents emergency situations, incidents, including the use of mechanical restraints, special instructions for supervision and monitoring of youth, population counts, security checks, transports away from the facility, requests by law enforcement to access any youth, youth placed on controlled observation, admissions, and releases. The program does not utilize logbooks on each living unit. The program utilizes shift reports in which the supervisor verbally brief the incoming staff on the report from the previous shift. Staff sign indicating they have reviewed the shift report.

Shift reports are maintained on the living unit for forty-eight hours. Master control color codes are used to highlight specific documentation in the program's logbooks. A green highlighter is used for searches, intakes, released, transports, and perimeter checks. A blue highlighter is used for drills, weather/heat indexes, med-pass, and administrative checks. An orange highlighter is used for security alerts, precautionary alerts, calls the Central Communications Center (CCC), and abuse calls. A yellow highlighter is used for counts and the start of shift summary/review by the shift manager. A pink highlighter is used for refusals, meals, and showers.

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 maintain the security of the program through the control of and accountability for all keys used in the program. The written policy and procedures include key assignments and usage restrictions, inventory and tracking of keys, secure storage of keys when not in use, procedures addressing lost or missing keys, and the reporting and replacement of damaged keys. The distribution and collection of keys by the master control operator was observed throughout the annual compliance review. A review of the key inventory matched the actual key rings in use. Keys were observed to be stored in a secure storage box located in master control which is not accessible to youth. The storage box is separated in the four layers in which one layer contains dorm and food service keys, the second containing visitor keys, the third containing maintenance and education keys, and the fourth layer contains clinical and case management keys. The lower portion of the lock box contains a drawer with five sections which are used for securing van and medical keys. Each key was observed to be marked with a numbered identification tag. Each set of keys has an assigned key hook. Visitors turn in their keys to the master control operator and are issued a chit with a corresponding hook number. Visitors turn in their chits when exiting the program and receive their personal keys in return. Three random staff members were questioned to show what keys they had in their possession. All three staff members only had their assigned work keys in their possession. The master control operator conducts a key inventory on each shift. The chief of security conducts a weekly inspection of keys which is documented on the weekly safety inspections. The master control operator was able to explain restricted keys can only be given to the person they are assigned to and no other staff may have access to them. The master control operator maintains a daily sign-in and sign-out log for key and radios in which staff sign for. A review of Central Communications Center (CCC) reports for the previous six months reflected there were no incidents related to key control. interviewed staff were familiar with the key control process and what to do in the event of a lost or damaged key.

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 to maintain the security and safety of the program by searching for, detecting, storing, and disposing of contraband/unauthorized items within the program. According to the written policy and procedures, contraband is defined as any unauthorized item determined to be in the possession of a youth or within the facility and accessible to youth which poses a threat to the safety, security, and operations to the facility. Identified contraband items include but are not limited to illegal items, sharps, escape paraphernalia, drugs, to include prescription or over the counter medication, tobacco products, electronic or vaporless cigarettes, non-program issued electronic equipment or devices, unauthorized food or beverages, metals, cell phones, cash, or keys. The program's youth handbook includes items which are considered contraband and possible consequences for being in possession of contraband. A review of seven youth records reflected an orientation checklist which included the review of the program's contraband policy in which all seven youth signed and dated. The program conducts searches of the physical plant, the facility grounds, youth, and incoming and outgoing mail. According to the written policy and procedures, if an employee who is found with contraband in the program is subject disciplinary action up to dismissal. In addition, law enforcement will be contacted if any item found is considered illegal as defined in Florida Statutes. The room search binder for the program was available for review. Documentation for the previous six months reflected random room searches are conducted daily by staff. In the event contraband is found; it is confiscating, noted on the search form, and filed in the youth's case record. Any illegal contraband is turned over to law enforcement. Search documentation was additionally observed being called in by staff to master control and documented in the program's logbook. The facility administrator reported the discovery of contraband and illegal contraband are documented on the internal contraband form. Additionally, contraband is removed from the area and placed in a trash receptacle. Illegal contraband is also documented on a contraband search form followed by preservation of the item. Illegal contraband is reported to the Central Communications Center (CCC) and possibly local law enforcement depending on the item discovered.

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 searches in order to ensure no contraband is being introduced into the program. During the annual compliance review, youth were observed being searched before and after movement of education and vocational classes, going on a transport, movement to and from the cafeteria, and movement to and from the dorms. Searches were observed to be conducted by a staff member of the same gender as the youth. Youth were observed being treated with dignity and respect during the observed searches. Staff were overheard giving instructions to the youth during the search. Searches conducted by staff were conducted according to the Protective Action Response (PAR) training manual. Searches for an admission, group, and return from off-campus activities were unable to be observed during the annual compliance review. Seven staff interviews reported searches are conducted during any movement of the youth. Seven interviewed youth reported searches are conducted when returning from off-campus, after outdoor activities, when items are missing, after visitation, meals, and every 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.	

The program currently utilizes four vehicles for transportation of youth. The program's vehicle maintenance binders were available for review. Three of the four vehicles used to transport youth were on-site. The fourth vehicle was off-site at the automotive shop for the scheduled annual safety inspection. Invoices reflected the three vehicles received their annual safety inspections on July 1, 2019, October 7, 2019, and May 20, 2019. All three vehicles contained fire extinguishers, approved first aid kits which were inspected weekly by medical staff), seat belt cutters, window punch, and the appropriate number of seatbelts. Additionally, youth are not attached to any part of the vehicle by any means other than the proper use of a seat belt. Vehicles were observed to be secured when not in use. A random inspection of personal vehicles in the program's parking lot was conducted and found vehicles to be secured.

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

The program has a written policy and procedures to ensure the security and safety of youth and the community when youth are transported outside of the facility. The written policy and procedures ensures compliance of all requirements outlined by the Department relating to transportation of youth and driver eligibility. Staff are issued a transportation cell phone when transporting youth. On the second day of the annual compliance review, five youth were observed were being transported to an outside appointment. The youth were observed being

searched by a staff member of the same gender prior to the transport. The youth were accompanied by two staff members of both the same gender as the youth. Youth and staff were observed wearing seatbelts upon exiting the program. Both staff members were able to produce a valid driver's license and were on the program's approved driver's list which was posted in master control and signed off on by the facility administrator. Employee driver's license are checked annually by the human resources manager and updated as necessary. A random inspection of personal vehicles in the program's parking lot and inspection of facility vehicles was conducted and found vehicles to be secured. Seven interviewed staff reported staff are issued a cell phone when transporting youth. All seven staff reported they are not allowed to use a personal vehicle for transporting 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 to ensure the safe and efficient operation of the physical plant and to protect against the development of conditions which may have the potential to adversely affect the health, safety and welfare of youth, staff, and visitors. The written policy and procedures outline who is responsible for conducting the weekly security audits and safety inspections, the development and implementation or corrective actions warranted as a result of safety and security deficiencies found, and an internal system to verify deficiencies found are corrected. The program's chief of security is responsible for conducting weekly safety audits. A sample of weekly safety audits were available for review. The sample reflected audits are being conducted weekly as required. Once the audit is completed, the facility administrator (FA) will review and sign off on the audit. Additionally, the audits are submitted to the Department weekly on every Wednesday, as required. According to the FA, the program follows a risk management system which requires daily, weekly, and monthly fidelity checks of program operations which are reviewed by the FA and discussed during monthly coaching sessions with department heads and monitored for improvement. In addition to the monthly session, the FA also discusses deficiencies during the morning management meetings, monthly all campus meetings, and shift supervisors addresses deficiencies during shift briefings.

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 ensuring the proper control of tools and kitchen utensils used within the facility as part of an overall strategy to prevent escapes and eliminate the threat of harm against staff, visitors, volunteers, interns, and youth. Tools are securely stored when not in use. All tools are marked for easy identification. The program utilizes a shadow board in which all tools are outlined. All tools are inventoried prior to being issued for work and following work activities. All tools are inventoried daily such as sharp edged or pointed tools. A daily tool inventory was available for review. Damaged tools were clearly identified on the perpetual inventory, tagged, and will be replaced. Tools in the kitchen, youth living area, and main maintenance area matched the actual tools on hand. In addition to the main maintenance area, a shed is utilized to house tools in whichyouth do not have access to this area. A review of the master inventory in the shed reflected three discrepancies were a square head shovel count was off by two, hoes was off by one, and hand shovels were off by two. All other items on the master inventory list in the shed matched the actual number of items on hand. The physical plant manager was hired on October 7, 2019 and reported the master

inventory would be updated immediately. Seven interviewed youth reported they are allowed to use mops, brooms, and scrub brushes. Additionally, one of the seven interviewed youth reported using a hammer, screwdriver, and saw while participating in the vocational class Home Builders Institute.

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

The program has a written policy and procedures ensuring youth use tools safely and are supervised appropriately in order to prevent injuries to youth, other youth, and staff. The written policy and procedures address specific ratios, tool distribution and collection, and search criteria. Two youth are currently assigned to maintenance personnel. Both youth are eligible to use tools according to their risk assessments. Youth were observed during the annual compliance review assisting maintenance personnel refilling toilet paper and paper towels in the bathrooms. Staff to youth ratio during work projects is one to five. Youth were observed being searched entering and exiting the maintenance area. One youth was observed sweeping the kitchen area after lunch in which the youth was being directly supervised by one staff member. Seven interviewed youth reported they are allowed to use mops, brooms, and scrub brushes. Additionally, one of the seven interviewed youth reported using a hammer, screwdriver, and saw while participating in the vocational class Home Builders Institute. Five of seven interviewed staff reported youth use mops and brooms. One staff member reported youth can use tools if enrolled in the vocational class. One staff member reported youth are not allowed to use tools.

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

The program has a written policy and procedures establishing guidelines required for outside contractors which includes information about tool control and restrictions. The program utilizes a Notice of Tool/Equipment form for outside contractors with instructions to include a maintenance staff member will inspect all tools prior to entering the facility, a final inspection of the work site will be completed, at no time should tools be left unattended, limit the tools used to only those necessary to complete the job, sign-in and sign-out of the facility, no items will be given to any youth, appropriate behavior will be maintained at all times, and if a tool is missing immediately notify the facility administrator (FA). This form is given to all outside contractors prior to any work occurring on-site. Each contractor must sign the form which indicates the contractor agrees to and understands the rules. The outside contractor binder was available for review. Invoices matched the sign-in dates on the Notice of Tool/Equipment Instructions forms signed by the outside contractor. The forms were observed to be filled out in their entirety. The contractor's tools are inventoried by the physical plant manager upon entry and exit from the program. According to the written policy and procedures, the FA has the discretion to give written approval for staff to bring in electronic communication devices and/or devices capable of taking pictures in which an approved list of staff who can bring in these items will be placed in master control.

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

The program conducts fire, safety, evacuation, and disaster drills in order to be prepared for immediate implementation or mobilization of the plan whenever an emergency arises. Fire evacuation routes and egress plans were observed to be posted throughout the facility. Fire extinguishers were observed to be conducted annually. The program provided documentation of drills conducted for review. The documentation for drills included the type of drill, date and time, participants, brief scenario, and findings to include recommendations. Drills are conducted consistently with the program's Continuity of Operations Plan (COOP). The COOP outlines specific plans for evacuation, major disturbance, terroristic threat, chemical spills, and weather disasters. Fire drills were observed to be conducted monthly and on each shift as required. Seven interviewed staff reported they have participated in a weather, escape, fire, medical, and suicide drills within the past twelve months. Seven interviewed youth reported they had been instructed on what to do in case of a fire. Four youth reported drills are completed monthly, one reported twice per month, one did not know, and one reported only being in the program for two months and participated in three drills. The facility administrator reported fire and medical drills are conducted once a month per each shift, a COOP drill once a year, and escape drills quarterly. In addition, mock suicide drills are completed at least quarterly per each shift.

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

The program has a coordinated disaster plan and Continuity of Operations Plan (COOP). The COOP is located in master control, supervisor's office, break room, and the facility administrator's office. The COOP is reviewed and updated annually and was submitted to the Department's residential regional director/designee and signed on May 6, 2019. The plan provides for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth, and the public. Provisions of equipment and supplies required for continuous operation and services during an emergency were observed. Additionally, the program maintains a hardcopy of critical identifying information for each youth in the event of an emergency resulting in a relocation. The binder with the required critical information for each youth was observed in master control. The facility administrator was interviewed and confirmed the locations of the COOP.

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

The program has a written policy and procedures in place to ensure all youth and staff are safe from the effects of unauthorized use of flammable, poisonous, toxic, and caustic materials. The facility administrator, assistant facility administrator, physical plant manager, dietary manager, and shift managers are authorized to draw and utilized these materials:. Observations of the list of these positions was posted in each area chemicals are stored. The program's flammable, poisonous, and toxic items are secured at all times when not in use and stored in an area which is not accessible to youth. Chemicals were observed to be stored in a secure closet in the youth living units, a secure closet in the kitchen, and a secure shed in the maintenance area. Corresponding Safety Data Sheets (SDS) were observed for each item. The inventories in the living units and kitchen matched the actual number of items on hand. One discrepancy was noted in the secure shed. The inventory listed six bottles of bug spray in which there were none on hand. This was the only discrepancy observed of all the items in the shed. The plant manager reported the inventory will be updated immediately to reflect the correct number.

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

The program has a written policy and procedures in place to ensure all youth and staff are safe from the effects of unauthorized use of flammable, poisonous, toxic, and caustic 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, use, handle, or dispose of danger or hazardous chemicals, bio-hazardous materials, bodily fluids, or human waste. These items have restricted access and are stored in secure areas. At no time during the annual compliance review were youth observed using these items. One youth was observed sweeping the kitchen floor and one was observed wiping down the kitchen tables with a cloth. The program's Preventative Maintenance Checklist and schedule was available for review. Maintenance schedules and repairs were observed to be conducted as outlined in F.A.C. 63E-7.109. Five of seven interviewed youth reported they do no use chemicals. Two reported they use window cleaner, bleach, floor wax, and rubbing alcohol. Youth additionally reported staff spray the chemicals and the youth wipe down the area.

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

The program has a written policy and procedures in place outlining the control of hazardous materials. According to the written policy and procedures, the facility administrator, assistant

facility administrator, physical plant manager, dietary manager, and shift managers are authorized to handle these item. These staff received training on the handling and disposal of these items. All hazardous materials are disposed of in accordance with the Occupational Safety and Health Administration (OSHA) Standard 29. Biohazardous waste is disposed of on a monthly basis through Stericylce. Biohazardous waste disposal logs were available for review. The program also utilizes the St. John's County landfill for disposal on an as needed basis. The program is also contracted with Advanced Garbage Disposal for the disposal of kitchen grease on an as needed basis. According to the written policy and procedures upon becoming aware of a chemical spill, staff will immediately notify master control and the shift manager. The area will be assessed and evacuated if necessary. Ventilation systems will be shut down and in conjunction with the facility administrator, a determination will be made on whether to request outside assistance. The facility administrator reported all contaminated garments and items must be disposed of in the biohazardous 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's written policy and procedures does not allow youth to participate in water-related activities; therefore, this indicator rates as non-applicable.

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

The program has a written policy and procedures by which the program may provide youth with opportunities to re-establish and maintain family and community ties to be involved in first person communications with attorneys and their agents, approved law enforcement, court, Department staff, and to ensure control of community access to the program. The program's posted activity schedule reflected visitation is held on Sundays from 2:30 p.m. to 4:30 p.m. Upon admission to the program, each youth's parent/guardian is mailed an admission/welcome letter within forty-eight hours. The letter outlines the visitation rules and process. In addition, the youth receive a handbook which outlines the rules for visitation and communication. Visitation, phone, and correspondence logs were available for review. Observation of phone call schedules were posted on the case manager's office doors in the youth living areas. Youth phone calls are facilitated by the assigned case manager and initially last ten minutes. As youth progress through the program, call time can increase up to thirty minutes. Youth may also use their points at the point store to purchase more phone time. Youth may send and receive letters to anyone on their approved correspondence list. All mail is reviewed and searched by the youth's case manager before being received or sent out. The written policy and procedures reflect only the facility administrator can approve special visits. Seven interviewed youth reported they can make phone calls and write letters.

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 has a written policy and procedures to ensure youth are to control their behaviors in a manner which is safe to the youth and the facility. The program's controlled observation room meet the requirements set forth by the Department. There has been a total of nine usages of controlled observation within the previous six months. Five incidents of the use of controlled observation were reviewed. 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 program has a written policy and procedures to ensure youth are to control their behaviors in a manner which is safe to the youth and the facility. There has been a total of nine usages of controlled observation within the previous six months. Five incidents of the use of controlled observation were reviewed. None of the five reviewed reports reflected 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 five reports indicated youth who were placed in controlled observation met the required criteria. Documentation in all five reports reflected youth were made aware of the reason for their placement in controlled observation. Three of five reports reflected the health status checklist was completed by a staff member of the same gender. Two

reports reflected the checklist was completed by a member of the opposite gender, which is allowed per administrative rule if a staff member of the same gender is unavailable. All five reviewed reports reflected the youth were released from controlled observation in two hours or less. Six of seven interviewed youth reported they have never been sent to their room for punishment reasons. One youth reported they were sent to their room for punishment reasons.

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.	

The program has a written policy and procedures to ensure youth are to control their behaviors in a manner which is safe to the youth and the facility. The program had a total of nine usages of controlled observation in the previous six months. Five controlled observation reports were reviewed. Each report reflected the staff making placement completed the first page of the controlled observation report and submitted it to a supervisor. Five reports reflected staff conducted and documented safety checks at least every fifteen minutes and observed the youth's behavior. All safety checks and observations were documented on the Controlled Observation Safety Check form. Each of five reports reflected the 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 file and in the youth's individual management case record. Documentation in five reports reflected the program director or designee reviewed the controlled observation report within fourteen days and indicated whether placement was appropriate.

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

The program has a written policy and procedures in place to identify stimuli which have both positive and negative effects on youth in the program. The program's safety plans include warning signs identified by the youth and/or collateral contacts, youth's baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies, and a debriefing process. Two binders which held youth safety plans were observed in the staff break room near master control where shift debriefings occur. Seven youth safety plans were reviewed. All seven plans were developed within fourteen days of the youth's admission to the program. Four of seven plans were developed jointly by the youth and collateral resources such as a parent/guardian and previous assessments. Three of seven plans were developed with the youth and did not include any information from collateral resources. Seven plans were updated; however, six of the seven plans were not updated every thirty days. The plans were over thirty and ninety days late. A shift briefing was observed during the annual compliance review in which the safety plans were discussed with staff. Six interviewed youth reported they were involved in the development of their safety plan. One youth reported they were not involved. Five of seven interviewed staff reported youth safety plans were on the dorm or in the case manager's office, two reported they did not know where the plans were located. Three staff were unaware of the process for reviewing safety plans. Four staff responded the youth safety

plans were reviewed each week, the therapist reviews the plan with the youth, plans are updated monthly, and the plan is reviewed at treatment team.