STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Hillsborough Girls Academy

TrueCore Behavioral Solutions, LLC.
(Contract Provider)
9056 East Columbus Drive
Tampa, Florida 33619

Review Date(s): July 16 - July 19, 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:

Amanda Nelson, Office of Program Accountability, Lead Reviewer (Standard 1)
Pamela Adams, Office of Program Accountability, Regional Monitor (Standard 4)
Jamila Bacchus, Office of Program Accountability, Regional Monitor (Standard 2)
Felicia Goldstein, Office of Program Accountability, Regional Monitor (Standard 3)
Danielle Lentchner, AMIKids, Inc., Compliance Manager (Standard 5)
Stephanie Lobzun, Office of Program Accountability, Co-Lead Reviewer (Standard 1)
Canitha Taylor, Office of Program Accountability, Deputy Supervisor (Interviews)
Jonathan Thompson, Office of Program Accountability, Regional Monitor (Standard 4)
Sherri Wilson, Office of Technical Assistance, Technical Assistance Specialist (SPEP)

Program Name: Hillsborough Girls Academy
Provider Name: TrueCore Behavioral Solutions
Location: Hillsborough County / Circuit 13
Review Date(s): July 16 - July 19, 2019

MQI Program Code: 1224
Contract Number: R2111
Number of Beds: 20
Lead Reviewer Code: 177

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
3.11 Suicide Prevention Services *	

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/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	Satisfactory

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Hillsborough Girls Academy is a twenty bed program, for thirteen to eighteen-year-old females for high risk commitment and fourteen to twenty-one year old females for maximum risk commitment, located in Tampa, Florida. The program is operated by TrueCore Behavioral, LLC., through a contract with the Department. The program provides mental health overlay services (MHOS). In addition, the program fosters each youth by providing Thinking for a Change (T4C), VOICES, Teen Relationships, Impact of Crime (IOC), Mean Girls, SAVVY Sisters, "Don't Let Youth Emotion Run Your Life", and dialectical behavior therapy (DBT). Additional treatment services provided includes family and individual therapy, conflict resolution, stress management, recreation therapy, anger management, impulse control groups, and Healthy Body and Brain Matters. Program administration is comprised of a facility administrator, assistant facility administrator, director of case management, director of clinical services, and a health services administrator. Case management services are provided by the director of case management and transition service manager. Mental health staff at the program includes the designated mental health clinician authority (DMHCA) who is a licensed clinical social worker (LCSW) as well as two full-time non-licensed master's-level therapists. There are also pro re nata (PRN) non-licensed master's-level therapists. The program has an agreement with a medical doctor (MD) to serve as the program's psychiatrist to provide services weekly and is on-call for emergency consultation twenty-four hours a day. The psychiatrist has an advanced practice registered nurse (APRN) to serve as the backup psychiatrist on an as needed basis. The program also has an agreement with a psychologist to provide services, as needed and contracts with a board certified behavior analyst to provide services, as needed. Medical services are offered from 7:00 a.m. to 3:30 p.m., Monday through Friday and are provided by two registered nurses. The designated health authority is a MD contracted with the program to provide medical services for two hours weekly and provide on-call service twenty-four hours a day for medical emergencies and consultations. The program has a contracted psychiatrist who provides psychiatric services and medication management at the program for one hour a week. Human Immunodeficiency Virus (HIV) counseling and testing services are provided by Metro Wellness Center from a certified counselor. Educational services are provided by the Hillsborough County School Board. The layout of the program includes: one building which includes two dormitories, a multi-purpose room, two classrooms, a medical clinic, a group room, master control, and an administrative area. The program has thirty-two operational security cameras providing coverage. At the time of the annual compliance review, the program had six vacant positions; five youth care workers and one part-time maintenance staff person.

Strengths and Innovative Approaches

- The program hosted a baby shower for a youth who was expecting a child, so the youth could experience the excitement of celebrating with the program while preparing for the birth of their child. The youth was able to complete a registry for items needed, and staff contributed items as well.

- The youth knitted and crocheted seatbelt covers for cancer patients to help cushion the patients port-a-catheters.

- The program provides youth the opportunity to earn their professional hair braiding licenses.

- The program participates in ”Kids and Canines” which is a therapeutic dog program to help youth learn how to care for an animal and develop skills to use if they chose to work with animals in the future. Three dogs have come through the program within the past year and were adopted as a result of the program. Eight youth were able to receive their dog trainer certification through this program.

- The program provided an “Colors and Canvas Night” with drinks, food, and art to help youth develop an appreciation and skills for the arts. The youth was also able to learn how art can be used as a coping skill.

Standard 1: Management Accountability

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

The program has a written policy and procedures for initial background screening. The program had nine newly hired staff since the last annual compliance review. There were sixteen volunteers and/or mentors applicable for an initial background screening. Reviewed documentation supported the nine newly hired staff and sixteen volunteers and/or mentors received background screenings completed by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each individual's date of hire and/or contact with youth or access to confidential information. There was evidence in all nine employee records indicating the hiring authority reviewed the Central Communications Center (CCC), Staff Verification System (SVS), and the Florida Department of Law Enforcement (FDLE)Automatic Training Management System (AMS) as part of the pre-employment background screening process. All nine newly hired staff and sixteen volunteers and/or mentors were added to the Clearinghouse employment roster. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the BSU on December 5, 2018, meeting the annual requirement. The Hillsborough County School Board's Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's BSU on December 7, 2018, meeting the annual requirement. Each direct care staff hired after July 1, 2018 is required to complete a pre-employment assessment and receive a passing score. The program had five direct staff hired after July 1, 2018, requiring a pre-employment assessment. The required pre-employment assessment is called the Ergometrics IMPACT for Juvenile Corrections Exam. Documentation reviewed found a pre-employment assessment was completed by the five newly hired direct care staff and a copy of the passing score was maintained in each staff's personnel record.

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

The program has a written policy and procedures for conducting five-year rescreening for all staff, volunteers, and interns in accordance with Department requirements. The program had one contracted staff member who met the requirements for a five-year background rescreening. The contracted staff member had a rescreening completed prior to their five-year anniversary date, with the information submitted to the Department's Background Screening Unit at least ten

days prior to their anniversary date. There were no volunteers, mentors, or interns who were applicable for a five-year rescreening.

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

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

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

The program maintains a written policy and procedures which outlines an environment free of abuse and neglect in which youth and staff feel safe and secure. Additionally, the program maintains an employee handbook which outlines the program's code of conduct to include trauma responsive practices. All staff are required to sign and acknowledge receipt of the employee handbook and code of conduct which outlines the grievance policies and their understanding of the program's code of conduct. A review of ten personnel records found each record contained documentation of acknowledgement, receipt, and review of the program's code of conduct. Observations conducted during the annual compliance review of a tour of the physical plant found postings of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) throughout the program. There is a telephone in the multi-purpose room which allows each youth to have direct access to the Florida Abuse Hotline. Youth are in the multi-purpose room multiple times throughout the day which provides opportunity for youth to make an abuse call, if needed. If youth are in another area of the program and wish to make an abuse call, staff will bring the youth to the multi-purpose room to allow each youth to call the Florida Abuse Hotline. All allegations of abuse or neglect, as well as CCC reports are logged and maintained in the program's logbook. Five interviewed youth reported they are aware of the abuse reporting process. Each youth reported never being denied access to contact the Florida Abuse Hotline or the Department's CCC. All five youth reported they always feel safe in the program and have never been denied any basic rights. Each interviewed youth described the staff to be respectful and reported they have never heard profanity or threats towards a youth in the program. Five interviewed staff reported they are required to allow youth to make an abuse call if requested and they have never observed another staff member telling a youth they could not make an abuse call. Each interviewed staff

was able to describe in detail the program's abuse and CCC reporting process. A review of all incidents since the last annual compliance review found there were no incidents which involved substantiated complaints against staff, nor were there any incidents which should have been reported and were not. The program completes a yearly TRACE self-assessment and surveys to gauge the level of trauma informed and caring approach to youth care is provided within the facility. During the annual compliance review, the review team did not observe any physical, emotional, or psychological abuse.

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

The program maintains a written policy and procedures which address management's response to allegations. A review of internal incidents and reports made to the Department's Central Communications Center (CCC) found the program had one incident concerning allegations against staff for incidents of physical, psychological, and/or emotional abuse since the last annual compliance review. Reviewed documentation for the incident reflected management immediately initiated an internal investigation and placed the staff member on administrative leave. The incident was unsubstantiated and the employee returned to work upon completion of the abuse investigation by the child protective investigator and law enforcement as well as the result of the internal investigation. During an interview with the facility administrator, it was reported staff are trained on incident reporting as part of their pre-service training.

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

The program has a written policy and procedures regarding reports to the Department's Central Communications Center (CCC). The program had five incidents reported to the CCC during the last six months, of which all five were reviewed. Documentation validated each incident was reported to the CCC within the mandatory two-hour time frame and in accordance with CCC reporting procedures. The program maintains a master logbook for documenting reports to the CCC and a review of the logbook supported three of the five incidents were documented in the logbook. The remaining two incidents involved a medical incident and a staff allegation incident which was not documented in the logbook due to confidentiality. A review of internal incidents for the past six months determined there were no incidents which should have been reported to the CCC and were not. A comparison of reportable incidents during the same time period last year showed a decrease of the reportable incidents from eight incidents during the same time period last year, to five incidents this year. The program's facility administrator stated all youth are explained their rights and how to report abuse during their orientation.

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

The program has a written policy and procedures as well as a written plan, addressing the utilization of Protective Action Response (PAR). The program's PAR plan was approved by the Department's Office of Staff Development and Training in March 2018. The program had three PAR reports completed within the last six months, an additional two reports were reviewed for the period of September and October 2018 in order to review the required minimum of five reports. Each report reflected documentation showing each report included a review by a PAR-certified instructor and processed within the seventy-two hour required time frame by all required parties. Reviewed documentation showed all five reports documented a post-PAR interview conducted within thirty minutes of the incident. A review of the PAR incident reports and comments by the facility administrator (FA) or designee within seventy-two hours of the incident, was found in each PAR report. None of the reviewed reports required a PAR medical review. Documentation confirmed each report was processed by a supervisor and a PAR instructor to determine if use of force was consistent with the policy in each PAR report. The PAR incidents did not include the use of mechanical restraints and there were no allegations of abuse made by youth or injuries to youth or staff. The program maintains a PAR binder which contains all PAR reports and PAR monthly summary reports. The program's PAR rate has increased since the last annual compliance review. Program administration could not provide a reason why PARs have increased since last year. The program's PAR rate during the annual compliance review period was 1.16 which is below the statewide residential PAR rate of 1.51. Monthly PAR summaries were submitted to the Department within two weeks by the end of the month. An interview with the FA indicated all PAR incidents are reviewed by FA for appropriateness and then discussed with the program's management team during their daily management meeting. If necessary, youth will receive a special treatment team meeting for their behavior and receive appropriate consequences determined by the management team.

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

The program has a written policy and procedures addressing pre-service training. The program maintains a pre-service training plan and calendar for all new staff which was submitted to the Department's Office of Staff Development and Training on March 13, 2019 and approved on April 12, 2019. Pre-service training is provided through a combination of instructor-led, web-based courses, and on the job training. Five staff training records were reviewed for pre-service training. Four of five records reflected staff completed the certification process within 180 days of hire and completed all required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. The remaining staff member was terminated from employment prior to being employed 180 days. A reviewed of all five staff training records showed documentation to support each staff exceeded the required 120 hours of pre-service training. All contractual required trainings were completed for

all five staff reviewed. Documentation showed all training was delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro).

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

The program maintains a written in-service training plan which was submitted to the Department's Office of Staff Development and Training on March 13, 2019 and approved on April 12, 2019. Five applicable staff training records, including two supervisor's training records were reviewed for in-service training. Each reviewed staff training record documented the staff exceeded the twenty-four hours of in-service training requirements. Each staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff also completed training in professionalism and ethics, including standards of conduct, as well as suicide prevention. One staff member reviewed was terminated prior to completing the required semi-annual emergency response training, prenatal and neonatal staff education, and training in monitoring, observation, and emergency room care of pregnant females and their infants. Two supervisor training records were reviewed for completion of eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, communications skills, and fiscal. Reviewed documentation supported each supervisor exceeded this requirement. All trainings were delivered by qualified trainers and documented in the Department's Learning System (SkillPro). The program's contract requires staff receive training in the Prison Rape Elimination Act (PREA) every two years and all five training records reflected staff was trained in PREA. All three licensed nursing staff had the required current certification 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 addressing the grievance process. The program maintains a written training plan for all pre-service training which includes grievance process and procedures. The program's policy indicates if the youth requests assistance in filling out the grievance form the staff, family, and peers or other advocates can help the youth fill out the form or fill it out for them. A review of ten employee training records showed all staff received the required grievance process and procedures training. The program follows a three phase grievance process to include informal phase (Chatty Cathy form), formal phase, and appeal phase. Chatty Cathy forms allow youth to voice objections and informally file an issue or complaint prior to filing a formal grievance. Observations during the physical plant tour during the annual compliance review, found Chatty Cathy forms and grievance forms were available to youth in the dormitories and multi-purpose room. There is a locked box for all Chatty Cathy and

formal grievance forms in the multi-purpose room which youth have access to several times throughout the day. If a youth is not satisfied with the resolution from the informal phase they may submit a formal grievance form. The assistant facility administrator (AFA) acts as the program's grievance officer. The grievance officer or designee will respond to all informal grievances within thirty-six hours and all formal grievances within seventy-two hours. Any grievance alleging sexual abuse or sexual harassment must be responded to by the facility administrator within forty-eight hours. If the youth is not satisfied with the response from the formal grievance, the youth may appeal the decision. The facility administrator (FA) is responsible for handling all grievance appeals. The facility administrator will conduct a hearing, if necessary, and a written result of the hearing will be provided to all participants within twenty-four hours. An interview with the FA reflects understanding of the grievance policy and procedures. There was a total of twelve grievances filed in the last twelve months, of which five were reviewed. A review of five grievances revealed each grievance was resolved at the formal level and within the required seventy-two-hour time frame. Each grievance showed documentation of youth participation, supervisory oversight, and final outcomes. Five staff interviews were conducted in which each staff reported knowledge of the grievance process. Five interviewed youth stated they were aware of the grievance process and could request assistance in filling out the grievance forms, if needed.

1.10 Interventions and Facilitator Training	**Satisfactory Compliance**
The program shall implement 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 provides delinquency interventions through evidence-based practice, promising practice, or a practice with demonstrated effectiveness for each youth. Evidenced-based interventions are those designed to reduce the influence of risk factors related to re-offending behavior. The program utilizes Thinking for a Change (T4C), Dialectical Behavioral Therapy (DBT), VOICES, and Impact of Crime (IOC) as the delinquency intervention models with each youth placed in groups according to their identified individual needs. Due to the length of stay at the program, typically all youth will participate in all intervention groups during their stay at the program. This practice was confirmed by the facility administrator (FA). Interviews with the program's clinical director and FA confirmed delinquency interventions are delivered by the recreation therapist and master's-level therapists. The FA also advised the youth are matched with their therapists based on each youth's individualized therapeutic needs. A review of each of the designated staff's training records, reflected all staff had the appropriate education and qualifications to be hired in their respective positions and completed the required training to facilitate the delinquency intervention groups. Two direct care staff provide fidelity monitoring of intervention groups and have received the required training to do so. The program's daily schedule reflects delinquency intervention groups are conducted seven days a week, pursuant to the program's contract and a review of sign-in sheets confirmed this practice. Structured, planned programming, and activities are provided for a minimum of sixty percent of the youth's awake hours. A review of five youth individual performance plans supported each youth had at least one delinquency intervention goal addressing an identified priority need. A review of group sign-in sheets validated each youth was participating in an intervention group. A T4C group was observed during the annual compliance review which validated the group was delivered, as

designed. All five interviewed youth stated they participated in all groups including GLAD, SAVVY Sisters, VOICES, IOC, and Grief and Loss.

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

The program has a written policy and procedures which provides interventions and instruction focusing on developing life and social skill competencies to youth through classroom and group instruction, hands-on experiences, and role modeled by staff and program administrators. Youth receive life and social skill intervention services specifically addressing at minimum: communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking to include problem-solving and decision-making. The program provides groups and curricula including, Thinking for a Change(T4C), anger management, SAVVY Sisters, Mean Girls, stress management, conflict resolution, impulse groups, and teen relationships. Each youth is taught employability skills during leisure time by the case management staff or transition manager. Youth are taught how to generate a résumé, complete a cover letter, fill out applications, and interviewing strategies. The educational staff teach each youth how to use Microsoft Office and other necessary computer skills needed for employment. A review of the program's contract indicates the program has staff trained to provide all of their required life skills and intervention groups, as well as their mental health and substance abuse groups. A review of group sign-in sheets confirmed the program is providing all contractually required groups to youth according to the activity schedule. A review of five youth case management records showed all youth are participating in life and social skills groups and training as required. Interviews with the facility administrator (FA) and clinical director indicated youth attend delinquency and life skills groups daily and are provided an opportunity to practice these skills during their daily routine. Interviews with five youth indicated they are all currently participating in groups to include SAVVY Sisters, VOICES, and grief and loss group. Youth interviews also indicated they learn active listening skills, coping skills, and utilize role playing to model desired skills. All five interviewed youth indicated they have been able to use the skills they have learned in their daily routine.

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

The program provides delinquency interventions through evidence-based principles and practices of restorative justice. The evidenced-based interventions are those designed to reduce the influence of risk factors related to re-offending behavior. The program provides the Impact of Crime (IOC) twice a week in the evenings, in addition to community service projects which helps to increase awareness and empathy for crime victims and survivors. Youth have also participated in car washes to raise money for victim funds and local community charities. A review of staff training records showed three staff are trained to facilitate IOC. A review of five case management records showed two youth participated in IOC during the week of the annual compliance review. An informal interview was conducted with the recreation therapist who facilitates the IOC group to determine how youth are exposed to victim's perspective through victim speakers. The recreation therapist stated youth watch a video of six to eight victim

speakers over the course of three class days. Additionally, the recreation therapist has shared their own personal experience of victimization and how the recreation therapist coped with the trauma endured. According to interviews with the recreation therapist and facility administrator, youth have been very receptive to this personal experience testimony from the recreation therapist.

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

The program has a written policy and procedures which address gender-specific programming for a female population, pursuant to the contract. The program utilizes VOICES as the main gender-specific programming and their program specific Girls 4 Success model to meet the needs of the program's female population. The program utilizes the Girls 4 Success Model, which identifies signature strengths such as volunteer and family focused services in addition to therapeutic support, health and wellness, academic, and life skills services. The program also utilizes the SAVVY Sisters and Mean Girls groups which focuses on needs specific to the female population served by the program. The program also provides Healthy Body and Brain Matters which is focused on gender-specific health issues. The program provides gender-specific medical education to youth monthly to include eating disorders and hygiene, spa weekends, hair braiding classes and certification, and pregnancy information. Interviews with the facility administrator (FA) and clinical director indicated all treatment planning is individualized and focuses on the gender-specific therapeutic needs of each youth as evidenced by group sign-in sheets and the five youth interviews conducted during the annual review.

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

The program has a written policy and procedures regarding entering alerts into the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. During an interview with the program's facility administrator, it was confirmed the JJIS alert reports and internal alerts are distributed and reviewed daily by shift supervisors and administration, at the administrative morning meeting and quarterly with the designated health authority (DHA). Upon review of the alert lists, the supervisors discuss the alerts with all working direct-care staff at each shift briefing. There is an internal alert board maintained in the staff breakroom and is updated as needed by medical, clinical, and case management staff. A review of five youth records found each was applicable to having an alert entered into the program's internal alert system and the JJIS alert system. Reviewed documentation supported each youth

had the appropriate alert entered into the internal alert system and each was entered into the JJIS alert system. All applicable youth were removed or downgraded from alert status by appropriate staff in a timely manner. Three out of five youth records were applicable for documentation of alerts in the logbook and all three alerts were found in the logbook. The facility administrator (FA) confirmed only medical staff are able to remove or downgrade a medical alert and only mental health staff are able to remove or downgrade a mental health alert. Four of the five staff confirmed they are informed of medical and mental health alerts by the internal alert board, logbook, and shift briefings. One staff member responded "no" when asked how staff were informed about alerts.

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

The program maintains a written policy and procedures relating to the maintenance, creation, and storage of individual healthcare, mental health, substance abuse, and case management records for each youth. The program maintains individual, color coated, hardbound binders for case management, healthcare, and mental health and substance abuse records. Observations of the records found each labeled "confidential" and secured in file cabinets identified as "confidential" in assigned locked offices inaccessible to youth. Observations of the records showed each youth record had the required documentation on the spine and the front of the binder, to include the youth's name, date of birth, county of residence, date of admission, committing offense, and the Department identification number (DJJID). Reviewed records showed all the required recent information in chronological order. Documents were organized into required sections and information was separated into designated sections with tabs for legal, demographic, case management with treatment plan and interventions, and correspondence along with a miscellaneous tab.

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

The program has a process to promote constructive input from youth. The program maintains a youth advisory board comprised of youth enrolled in the program, giving youth the opportunity to have verbal contact with the program's administration regarding program operational issues, complaints, and/or suggestions. All youth who participate on the youth advisory board must apply, maintain a C grade average, remain on one of the last two phases of the program, and maintain good behavior. Additionally, the program utilizes "Chatty Cathy" forms, daily meetings, and weekly community meetings which gives each youth an opportunity to address both positive and negative issues they may have. The youth advisory board meets weekly with administration. Reviewed documentation revealed meetings were held twenty-five times during the past six-month period. Each meeting followed an individual agenda which addressed each request or complaint accordingly, either during the following month's youth advisory meeting or with program leadership. Some topics discussed during the youth advisory board meetings included level consistency, dietary issues, incentive calendar input, activity ideas, and leadership/mentoring. Five interviewed youth stated they could provide feedback and input if desired. All five interviewed youth reported being able to participate in student advisory boards and daily meetings as a way of providing input to the program. During an informal interview with

the facility administrator (FA), it was indicated youth can make suggestions to the FA at any time. Systemic issues are addressed during weekly youth advisory board meetings.

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

The program maintains a policy and procedures for maintaining an advisory board. The program has an advisory board in conjunction with Lake Academy and Tampa Residential Facility which are all located on the same compound. The program maintains a list of community advisory board members from the school board, law enforcement officials, community partners, faith-based organizations, a local mentoring agency, judiciary, business community, victim advocates, and parents/guardians of former/present residents. Reviewed documentation reflected the program's community advisory board met on September 13, 2018, November 15, 2018, February 21, 2019, and May 16, 2019. A review of the meeting minutes and an interview with a board member reflected each program was separately discussed during the meetings. There was clear documentation to support the program made attempts to schedule meeting dates and work around community advisory board member's schedules by the program's facility administrator mailing a letter, in advance of the scheduled meeting to increase attendance. Attempts were made for recruitment efforts from law enforcement, the judiciary community, other community partners, business community, school board, faith community, victim advocates, and parent/guardians. Reviewed community advisory board agendas and meeting minutes documented the program provides the board members with information regarding program updates, community updates, and giving back to the community. During an informal interview with an advisory board member, it was stated meetings are held quarterly and the program is very receptive to board member's feedback. One example of feedback provided by the board and incorporated by the program was the program to include mentor involvement for special events such as, Family Day for youth who may not have family present.

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

The program conducts monthly all staff meetings, monthly supervisor meetings, and daily management meetings to share information with staff and to enhance program planning. A review of the program's meeting binders indicated meetings are held monthly or daily and were held accordingly during the annual compliance review period. A review of the all staff meeting minutes indicated the program reviews with staff the quality improvement reports, red flag issues, medical updates, mental health updates, drill reviews, human resources issues, policy reviews, and safety and security issues. A review of the daily management meetings indicated the management team discussed programming issues, grievances, Central Communications Center reports, incident reports, youth issues, education issues, Protective Action Response (PAR) incidents, program trends, alert trackers, sick calls, and staff vacancies. Monthly staff meeting documentation reflected a review of the annual compliance report and the Comprehensive Accountability Report (CAR). The program also conducts parent/guardian surveys upon each youth's admission and discharge from the program, and a random sample of ten youth and parent/guardian surveys on a quarterly basis. The feedback received from the surveys is discussed with administration and used to enhance programming.

The program has a policy and procedures in place for employment recognition. The purpose of the policy is to recognize employees for their contribution to the program through their performance to create a culture of care. The program recognizes an employee of the month, employee of the quarter, and employee of the year. Each winner is awarded a pre-determined monetary gift. In addition, TrueCore programs are recognized with additional monetary gifts for meetings program goals which are utilized to facilitate staff parties and boost morale. The program also received a contract amendment this year to provide monetary bonuses to staff to encourage retention. The program also utilizes a program called the TrueCore Way for staff members going above and beyond, which allows supervisory staff or customers to recognize employees for exemplifying the TrueCore way. During an interview with the facility administrator (FA) and regional compliance manager, it was confirmed the program holds monthly staff meetings, monthly supervisor meetings, and daily management meetings to keep staff informed of events going on in the program. The FA stated the program has implemented a fun T-shirt and jeans Friday to boost employee morale. The regional compliance manager also established youth and parent/guardian surveys are conducted quarterly and the information collected is shared with staff and used to improve programming. Five interviewed staff members confirmed the program holds monthly staff meetings. The five staff indicated youth behavioral issues, youth alerts, program trends, drills, and department related topics are discussed during monthly staff meetings. None of the interviewed staff indicated they are briefed on annual reports or survey results. One staff member did indicate they receive significant amount of information and feedback from the program which may have been generated from survey results. All five interviewed staff indicated communication at the program is very good. All staff indicated the administration has an open-door policy and they can communicate any concerns with the administration.

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 addressing the evaluation of staff performance. Performance evaluations are completed annually for all staff by department heads. During an interview with the facility administrator (FA), it was found annual evaluations are completed to provide feedback to staff regarding their performance over the prior year to include implementation of the positive performance system (PPS) and their overall specific job duties. Goals are also identified for the upcoming year. Each staff is also given the opportunity to provide comments and written input during this time. Performance evaluation address performance standards to include job duties, job knowledge and competency, teamwork, professionalism, and goals achieved. Evaluations are explicit to different categories of staff positions. Staff can be rated as commendable, acceptable, needs improvement, unacceptable, or non-applicable. Each performance evaluation provides an overall numerical rating at the end of the evaluation. Five staff were interviewed about performance evaluations. Three staff indicated they receive annual performance evaluations, one staff indicated performance evaluations are completed every six months , and one staff member was new and indicated they only received a three-month probationary performance evaluation. Five personnel records were reviewed in which two were supervisory records. Each included the specific job description and applicable performance evaluation. All key positions were filled at the time of the annual compliance review.

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 along with the program's policy and procedures regarding recreation and leisure activities. The program has a range of supervised and structured indoor and outdoor recreation activities available to youth. Activities include basketball, volleyball, arts and crafts, work-outs, crocheting for cancer patients, poetry, and clay figurine modeling. The program currently has one recreational therapist in accordance with the contract. The education and qualifications of the recreational therapist was reviewed. The therapist is a master's-level recreational specialist who holds a degree in exercise science and physical education and wellness. Five interviewed youth indicated they are provided a variety of activities with varying degrees of mental and physical exertion throughout the day. Five interviewed youth and five interviewed staff indicated youth are provided with at least one hour of large muscle activity each day. During an interview with the recreation therapist, it was indicated the recreation activities promote community wellness which allows youth to contribute to the group culture, promotes social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. A review of the logbook reflected a minimum of an hour of recreation activity is provided daily for all youth. The youth have wellness plans and updates on the progress of those plans are provided to the treatment team monthly. The recreation therapist does not attend treatment team meetings but provides the information about the wellness plan program to the team prior to the meeting. Youth are provided an opportunity to provide input into the rules and operation of the program through the youth advisory board. Five interviewed youth indicated they view the youth advisory board as a positive process, since it has already resulted in some positive changes based on suggestions from the youth advisory board.

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 in place to ensure initial contacts are made to a youth's parent/guardian and committing court upon admittance to the program. The program requires phone contact with the parent/guardian within twenty-four hours, a written correspondence to the parent/guardian mailed within forty-eight hours, and notification to a youth committing court within five days of admission. Five youth case management records were reviewed. All records documentation confirmed case manager's contact communications were completed to each youth's parent/guardian, juvenile probation officer (JPO), and committing court in advance of the required time frames.

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 in place to ensure on the day of a youth's admission, the youth will be oriented on the programs rules, procedures, schedule, and services. The program provides a youth handbook detailing all the required elements highlighted in the Florida Administrative Code 63E-7.005. A youth's parent/guardian is also mailed a parent handbook covering all required elements. Five youth case management records were reviewed. All records contained an orientation checklist acknowledgement form signed by each youth confirming completion of an orientation. Each youth record revealed supporting documentation of an orientation being completed on same day of youth's admission. During the annual compliance review period, there were no new admissions scheduled; therefore, no observation of an orientation process was completed. Five interviewed youth confirmed receiving an orientation within twenty-four hours of their 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 to obtain written consent of any youth eighteen years of age or older, approval for release of their confidential information to a parent/guardian. Five youth case management records were reviewed and three were applicable for written consent. The program provided one additional youth case management record of a youth meeting written consent criteria. All three reviewed applicable records included an updated signed consent form completed by each youth prior to their eighteen birthday.

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 policy and procedures in place to address youth classification factors, procedures, and reassessments for activities to ensure safety and security with effective delivery of treatment services. An interview with the facility administrator (FA) discussing the process for assigning a youth to a living unit and sleeping room was conducted. The FA indicated, the Victimization and Sexually Aggressive Behavior (VSAB), Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), Facility Entry Physical Health Screening (FEPHS), Assessment of Suicide Risk (ASR), gang affiliations, criminal history, identified special needs, and history of violence is considered for determining room and living unit placement. The VSAB was completed in the provider computer system, Laurus upon the youth's admission into the program. The VSAB was not completed in the Juvenile Justice Information System (JJIS) the day of the youth's admission, as required. Upon a youth's admission to the program, a standard classification form is completed. This form is intended to outline vital information such as the youth's demographics, physical characteristics, maturity level, and identification or suspected risk factors for suicide, medical, escape and/or security. The gathered information is utilized for assigning a youth to a living unit, sleeping room, and youth group or staff advisor. Five youth case management records were reviewed. All records contained the standard classification form with required elements completed to its entirety. Four applicable records revealed documentation of identified or suspected risk factors, which all alerts were entered into the Department Juvenile Justice Information System (JJIS) and program internal alert system. One youth record did not have any risk factors requiring an alert in JJIS. The program utilizes a risk assessment form to conduct monthly reassessments for all youth in the program which is maintained in a risk assessment binder. A review of all five youth's risk assessments contained monthly input for an increase in program privileges. The program does not participate in work projects or off-campus activities; however, each of the five youth had monthly reassessments completed for a consideration of increase in program privileges.

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

The program has a written policy and procedures in place addressing gang identification and notification to the school district and law enforcement. Five case management records were reviewed and none were applicable for possible gang involvement. The program currently has two youth identified in gang related activities; therefore, their case management records were reviewed. One record indicated the youth was identified as a suspected gang affiliation prior to admission, and the remaining record indicated the youth admitted to program staff affiliation in gang activity during admission. The two records contained written notification to Hillsborough

County School Board and each of the youths' county law enforcement agency and juvenile probation officer. Each youth's record contained a documented alert in the Department Juvenile Justice Information System.

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 to ensure youth identified as gang related are provided gang prevention and intervention activities. During the annual compliance review period, two youth in the program were identified as suspected gang members. One of the applicable gang involved youth case management records revealed an individual performance plan addressing the need for gang awareness and intervention services. The other applicable youth record revealed youth gang identification in March 2019, prior to admission to the program. The gang awareness and intervention services were not added to the youth's individual performance plan until May 2019, as the result of the initial Residential Assessment of Youth (RAY) assessment. The program has a gang binder which maintains all documented information and program activities completed with gang identified youth. The program utilizes the ARISE curriculum as the selected gang prevention and awareness curriculum. One of the two gang involved youth was recently admitted to the program in July 2019 and has not started the curriculum activities. The other applicable youth record contains documented participation in the ARISE group.

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

The program has a policy and procedures in place to address completion of a Residential Assessment for Youth (RAY) assessment and re-assessment. The Department launched a new assessment tool entitled, Residential Assessment for Youth (RAY) in May 2019. The previous tool used by the program was entitled, Residential Positive Achievement Change Tool (R-PACT), which is no longer being utilized for any youth admitted to a program after April 8, 2019. Five youth case management records were reviewed and four were applicable for an initial R-PACT completion. All four youth R-PACT's were conducted within thirty days of admission as required. One applicable youth record contained completion of a RAY assessment within the required time frame.

A RAY re-assessment is required to be completed in ninety-day intervals, which none of the five records were eligible for a ninety-day re-assessment. Due to the implementation of the new assessment tool launching around the time-frame of possible re-assessments of the R-PACT,

the program completed an initial RAY assessment for all four applicable youth. Each assessment was completed within a month time frame of the launch. All five youth RAY assessments were maintained in the Department Juvenile Justice Information System and a copy located in their youth case management record.

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

The program has a written policy and procedures to ensure each youth has a completed Youth Needs Assessment Summary (YNAS) within thirty days of admission. Five youth case management records were reviewed and each contained an YNAS completion within the required time frames after the youth admission to the program. All five records indicated the YNAS was documented in the Department Juvenile Justice Information System.

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

The program has a policy and procedures to address performance plan development, goals, and transmittal. The program is required to complete a youth's individualized performance plan within thirty days of admission. The performance plan shall include input from the educational staff, treatment team leader, youth, administrative representative, living unit representative, treatment staff, and if applicable the Department of Children and Families (DCF) case worker or Agency for Persons with Disabilities (APD) support coordinator. Six youth case management records were reviewed to include the youth involved with DCF. All six records revealed a completion of individualized performance plans within the required time frames for five of the records. One youth case management record indicated the performance plan was one day late. All six performance plans outlined all the required elements, such as the youth's individualized goals, top three criminogenic needs, youth and staff responsibilities, delinquency interventions, court sanctions, target dates completion, and goals for transition. Documentation supported the youth's parent/guardian were included in the development of the performance plans. Each of the six performance plans included the required signatures from all parties except for the parent/guardian and for the one DCF youth. All six records contained a notation of the individualized performance plan was mailed to parent/guardian and DCF case worker with a request to return with the signature page signed. All parents participated in the development of the performance plan by telephone. One of six youth performance plans signature page was returned to the program signed. The program has documented attempts to obtain signatures

from the youth's parent/guardian on the individualized performance plan for the five applicable youth.

The program is required to send a correspondence of a copied individualized performance plan to the committing court, juvenile probation officer (JPO), parent/guardian, and DCF case worker within ten working days of completion. Each of the six youth case management records contained supporting documentation of communication in which the plan was sent within the required time frame. Five interviewed youth revealed all obtained a copy of their individualized performance plan and was able to explain their goals in detail.

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

The program has a written policy and procedures to address the revision of each youth's performance plan revisions based upon the Residential Assessment for Youth (RAY) re-assessment results. Eight youth case management records were reviewed. Five open and three closed records were reviewed. Seven were applicable for a ninety-day review. Due to the implementation of the Department's new RAY assessment tool going live around the time frame of a review of the discontinued Residential Positive Achievement Change Tool (R-PACT); an initial RAY assessment was completed by the program for six of the eight youth. One youth had an initial RAY completed in May 2019; therefore, the youth did not require a re-assessment. One youth was released from the program prior to the implementation of the RAY ; however, a R-PACT re-assessment was completed. The seven applicable youth records for performance plan revisions were based on the discontinued tool R-PACT re-assessment and the one youth record was based on the RAY initial assessment, completion of goals, and/or receipt of new information. The revisions for the individualized performance plan was completed to facilitate the transition activities for the three closed records.

Performance plan reviews were conducted on seven of eight reviewed youth records. One was not eligible for a ninety-day review. Six of seven eligible plans showed a new Residential Positive Achievement Change Tool (R-PACT) completed and plans adjusted based on any new information, goal completion, or transition expectations. One of seven applicable youth had an initial RAY completed for their performance plan revision, due to the revision being completed after the launch of the RAY.

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

The program has a policy and procedures to address the completion of performance summaries

and the transmittal of the summaries. Five open youth case management records were reviewed and four were applicable for the completion of a ninety-day summary.
Each applicable youth record included a performance summary completed with the required elements such as education input, overall treatment progress, level of motivation, and behavior. All performance plans were completed within the required time frame. All four youth were provided the opportunity to review the performance plan and add comments. Each summary was signed by the treatment team leader, facility administrator, and the youth and maintained in the youth's case management record. The four youth records showed copies of each respective summary sent to the committing court, juvenile probation officer (JPO), and parent/guardian within the ten-day requirement. Three closed youth case management records were reviewed. All three records showed a summary with justification for release sent with a Pre-Release Notification to the supervising JPO. None of the records contained an objection by the court or applicable for the sexually violent predator program. Upon approval from the court, the program provided mailed letters to all three parents/guardians of the anticipated release dates. The program completed the required applicable exit assessments once an approval of release for the youth was granted. Five interviewed youth all reported having copies of their summaries.

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

The program has a written policy and procedures to address facilitation, involvement, and encouragement of participation of the youth's parent/guardian in case management services. Five youth case management records were reviewed. Each record contained documentation of attempts through phone contacts and mail to involve the parent/guardian in the case management process. Team meetings facilitated by the program included encouragement of parent/guardian participation by phone or provision of written or verbal input when unavailable to attend. Case management also mail copies of youth documentation related to youth's progress in the program. During the annual compliance review, three youth treatment team meetings were observed. One parent/guardian was readily available to participate in the meeting. One parent/guardian was unavailable to participate. One parent/guardian requested for a follow-up phone call with youth updates due to the parent/guardian being at work and unable to participate. An interview with the facility administrator supported the program's parental/guardian involvement in the case management processes. Five interviewed youth confirmed the program's practice of parent/guardian involvement in treatment team meetings and other case management processes.

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

The program has a written policy and procedures to ensure each youth is assigned a treatment team. The treatment team members are representatives from each program area which each member role is to participate in a youth's informal progress review and formal treatment review. The members include the youth, parent/guardian, transitions services manager, treatment team leader, a mental health therapist and a juvenile probation officer (JPO). In addition, a living unit representative, clinical, and administrative representative, and if applicable the Department of Children and Families (DCF) case worker and/or Agency with Persons with Disabilities (APD)

support coordinator. Five youth case management records were reviewed and each contained supporting documentation of each youth treatment team meeting comprised with signatures of each required member attendance. One additional youth case management record was reviewed for a youth in custody of DCF. The DCF case worker was notified of treatment team meetings in advance and participated by phone, when available. During the annual compliance review, an observation of treatment team meetings for three youth revealed active participation by all required program staff, in addition available parties participated via telephonic by two youth's JPO and one youth parent/guardian. The program's case management director left a voicemail for one youth's JPO. One parent/guardian requested a callback from the program and one parent/guardian phone was not in-service.

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

The program has a written policy and procedures to address incorporation of other agencies into each youth's treatment and performance plan. Five youth case management records were reviewed. Each record revealed a youth's performance plan incorporated a treatment plan and an education plan. One additional case management record was reviewed for a youth in custody of Department of Children and Families (DCF). The youth's performance plan incorporated a DCF case plan, treatment plan, and educational plan. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD).

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

The program has a policy and procedures to address informal and formal treatment team meetings. Each youth assigned treatment team member is to participate in bi-weekly informal progress review and formal treatment review at least once every thirty days. Five youth case management records were reviewed. All records contained supporting documentation of completed formal and informal treatment team meetings within the required time frames. Each treatment team form included the youth's demographical information, date of review, members in attendance with required signatures, and written input from the education staff when not available. Additionally, each youth treatment team meeting included the youth's overall program and treatment progress, performance plan goals, and applicable revisions based on the initial Residential Assessment for Youth (RAY) tool. During the annual compliance review, an observation of treatment team meetings for three youth was conducted. Each youth was provided the opportunity to demonstrate their learned skills acquired from the program to all parties in attendance. All required staff were present with written input from education staff. One youth parent/guardian was present and was offered opportunities to actively participate. Two youth juvenile probation officers (JPOs) was present on the telephone and actively participated by providing input and asking questions. Two youth parent/guardian and one youth's JPO were unavailable for the meeting. During each treatment team meeting, the team actively participated by discussing each youth's overall performance in the program. A copy of all three youth treatment plans were obtained which included all the required elements and signatures. Each

youth's anticipated release dates were reviewed in the Department's Juvenile Justice Information System, confirming required updates of information were made as applicable. Five interviewed youth confirmed the program provides opportunities for youth to demonstrate acquired skills from the program during treatment team meetings. Each youth indicated their program and treatment progress is reviewed with them.

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

The program has a policy and procedures in place addressing career education. The program offers Type 2 career education services provided by the Hillsborough County School Board. Each youth in the program is assigned specific courses which can be completed within one to two semesters. Youth placement in a personal career and computer technical course is assigned with consideration of the youth's educational goals, age, skills, and ability. The program vocational competency development program focuses on enhancing a youth's personal accountability skills and behaviors leading to appropriate work ethics for employability and independent living standards. Additional skills a youth can obtain includes interpersonal, communication, and decision-making skills. The vocational program facilitated to the youth accommodates all age groups and educational ability levels, in addition to the youth's goals while in the program and length of stay. The career education programming is designed to provide youth with an orientation to the various occupations types which are directly related to each youth's individual abilities, aptitudes, and skill levels. A youth completing the program will participate in course work which includes résumé writing, completion of job applications, and college applications, if applicable.

Three closed youth case management records were reviewed. Supporting documentation was maintained in each respective youth's exit portfolio, an employment application, sample résumé, completed career assessments, essential documents to obtain employment, and contact information of a local Career Source Center. Each record contained documentation supporting notification to youth's parent/guardian and juvenile probation officer (JPO) of the youth's vocational plan. An interview with the program's lead teacher and facility administrator verified the program's practice.

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 has a policy and procedures in place to ensure youth have access to educational services. The program operates an academic program under the direction and supervision of the Hillsborough County School Board on a year-round basis. The youth in the program receive educational and vocational instruction for at least 250 days during the calendar year, with a minimum of twenty-five hours of instruction weekly. Teacher planning and professional development is dispersed across ten days of the 250 days. A review of the program posted daily schedule and an interview with five youth and the program's lead teacher supported educational instruction takes place as scheduled, with minimal interference. A review of the facility logbook for adherences to school hours schedule across fourteen dates was completed. Seven school start times were within or less than fifteen minutes of the designated start time of 7:45 a.m. Four dates were less than twenty minutes from the start time. Three days were thirty minutes from

the designated start time. Even though the schedule was not met, and the youth were late to school, the program met or exceeded the required weekly hours provided to the youth. The program acknowledged the reviewer findings noting the program school schedule post a total of 360 hours which exceeds the 300 hours requirement and allows programming or educational scheduling adjustments.

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

The program has a policy and procedures in place to address implementation and completion of youth educational transition plans. The Hillsborough County school district collaborates with the program in assigning a certified guidance counselor and registrar to assist with completing educational training plans. Three closed youth case management records were reviewed and no youth had an individual education transition plan developed upon admission to the program. Upon notification of youth expected release date from the program, the school district completed an educational transition plan for two of the three youth. One youth plan was not completed due to Hillsborough County school district assigned teacher responsible for completing all program plans unexpectedly passed away. The program acknowledged the school district has since acquired a new staff member to ensure education transitions plans are completed. The two youth with an educational plan involved the youth, parent/guardian, education representative, juvenile probation office (JPO), and post-release staff in development. The two youth records included employability as a transition goal and included provisions for continuation of education and/or employment. Additionally, each record included appropriate documents essential to obtaining employment and documentation of the youth’s case manager and parent awareness of the plan. Although one youth did not have supporting documentation of a transition plan, all essential documentation and processes were completed for youth to be deemed as gainfully employable and was maintained in the youth’s respective exit portfolio. All three youth respective exit portfolios included a copy of their State of Florida-issued identification card, a résumé, employment application, and a calendar with dates, times, and locations of follow-up appointments in the community. The two youth transition plans addressed all required elements including services and interventions related to the results on each youth assessed educational needs and post-release education plans, and services provision during program stay and release.

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

The program has a written policy and procedures to ensure the intervention and treatment team is planning for a youth's successful transition to the community upon release from the program. The program implements a youth's transition planning processes, conference, and Community Re-Entry Team (CRT) meeting sixty days prior to the anticipated release date. A review of three closed youth case management records was completed. Each youth received a transition conference, exit conference, and Community Re-Entry Team (CRT) meeting within the required time frames. All three youth received a CRT meeting which included the youth and case manager with confirmed invitation to participate through an email/outlook invite. All three youth parent/guardian and juvenile probation officer (JPO) were invited by letter. Educational and transitional staff were invited by e-mail notification to all conferences. All pertinent parties in attendance at the conferences included the youth, treatment team leader, program director, and other team members; in addition, to written input from education staff. The youth was provided the opportunity to actively participate in the development of the transition plan. Supporting documentation for all three youth indicated the necessary review and revisions to the performance plan were discussed; in addition, to identification of transitional activities, target dates completion, and delegated parties responsible for completing activities. Each youth record included the required signatures of parties in attendance for meetings and mailed copies sent to parties not in attendance. The program also mailed a copy to the JPO for review and signature.

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

The program has a policy and procedures to address the completion of an exit portfolio for youth being released back in the community. Three closed youth case management records were reviewed for completion of an exit portfolio. Each youth completed a transition and exit conference and were provided a copy of their respective exit portfolio with signature acknowledgement for receipt of their exit portfolio upon discharge. One of the three youth court committed status was determined as a maximum-risk youth which the youth transition plan entailed all responsible parties working with the youth to obtain documents for an exit portfolio, clear instructions, and assistance with completing the forms. All three youth exit portfolios included the transition plan, completed assessments, a résumé, employment application, educational records, and vocational certifications. The program education staff forwarded the

exit portfolio information to the receiving school district. Additionally, each youths respective portfolios included a copy of their State of Florida-issued identification card, birth certificate, transition plan, calendar with dates, times, and locations of follow-up appointments in the community. One of three exit portfolios contained a copy of the youth's social security card; however, the program completed attempts to obtain the card for the remaining two youth was verified. The program staff sent a copy of each youth's exit portfolio to their respective juvenile probation officer (JPO).

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

The program has a written policy and procedures to address the requirements for each youth's exit conference. Three closed youth case management records were reviewed. Each record included documentation of notification to the juvenile probation officer (JPO) of the youth's release prior to the program conducting an exit conference. All three youth exit conference was held within fourteen days prior to release from the program. The exit conferences were separate from the Community Re-entry Team meetings. A review of documentation confirmed all three youth exit conference included a summary of pending transition goals, finalized activities, dates and signatures of all parties in attendance. Attendees who participated in the conference telephonically was documented on the signature line and a written input from education. The treatment team leader, parent/guardian, JPO, youth, and other team members attended all three exit conferences. A review in the Department's Juvenile Justice Information System (JJIS) correlated with each youth's date of admission and termination documented in each record.

Standard 3: Mental Health and Substance Abuse Services

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

The program recently hired a licensed clinical social worker who serves as the program's designated mental health clinician authority (DMHCA). The DMHCA is also a master's-level certified addictions professional and licensed in the State of Florida through March 31, 2021. The DMHCA is a full-time position and is on-site at least forty hours a week, five days a week, with additional hours as needed. The company employs a regional clinical director (RCD) who is a licensed mental health counselor in the State of Florida through March 31, 2021. The previous DMHCA is currently a licensed mental health counselor in the State of Florida through March 31, 2021 and vacated the full-time position in May 2019. The previous DMHCA currently works with the program on an as needed basis. The RCD serves as a back- up to the DMHCA. The DMHCA and RCD are on-call twenty-four hours a day, seven days a week for consultation. The program provides mental health overlay services to all youth. The DMHCA position description indicates the responsibilities for the coordination and implementation of mental health and substance abuse services to include all specialized treatment services. An interview with the DMHCA and RCD verified the DMHCA's role in the coordination and implementation of services in the program.

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

The program's policy, procedures, or contract does not require any other licensed clinical staff other than the individual serving as the designated mental health clinician authority (DMHCA); therefore, this indicator rates as non-applicable.

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 currently has two full-time, non-licensed master's-level therapists to provide mental health and substance abuse services to youth. The program has utilized the services of five non-licensed mental health staff on an intermittent basis during the annual compliance review period. All the non-licensed staff utilized were master's-level and had the required field of study and experience. All non-licensed clinical staff received the required training with the exception of one clinical staff who was recently hired and still within their first 180 days of employment. This program is currently licensed by the Department of Children and Families (DCF) under Florida Statues, Chapter 397, to provide outpatient substance abuse treatment services and all non-licensed staff providing substance abuse services in the facility have received the required training. A review of five youth mental health and substance abuse records revealed a licensed mental health professional reviewed and signed all Assessment of Suicide Risks (ASR), Follow-Up ASRs, Crisis Assessments, and Comprehensive Bio-Psychosocial Evaluations conducted by a trained non-licensed staff. A review of the clinical supervision log found all non-licensed clinical staff providing treatment, full-time and pro re nata received one hour of on-site, face-to-face or individual supervision each week they provided a service to the youth. The documentation of the direct supervision was recorded on a form which included all elements on the Department's form.

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 comprehensive plan for delivery of mental health services which describes the screening process for all newly admitted youth. The program utilizes the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) to screen every youth upon admission. The MAYSI-2 is completed in the Department's Juvenile Justice Information System (JJIS) by a trained staff member on the day of admission in a confidential manner. Five youth mental health and substance abuse records were reviewed for completion of MAYSI-2 screening. All screenings were completed on the day of admission and by a licensed mental health clinician or the designated mental health clinician authority (DMHCA). None of the five youth required further assessments on the MAYSI-2 for suicide risk, however; it is the program's current practice to refer all youth at the time of admission for a new comprehensive mental health and substance abuse evaluation and an Assessment of Suicide Risk (ASR), regardless of MAYSI-2 results. Additionally, the program also competes a Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and Adolescent Substance Abuse Subtle Screening Inventory (SASSI) on all youth to identify those youth at risk for mental health and substance abuse issues. When determining placement of a youth with substance abuse needs, and the need for continued stay; clinical staff use guidelines outlined by the Florida Supplement to the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2-R) Second Edition. All records contained a records review form giving a summary of the commitment documentation reviewed

at admission which included but was not limited to family history, history of trauma, drug/alcohol use, emotional instability, and risk and protective factors. The licensed mental health professional also reviewed and signed all ASRs conducted by non-licensed clinical staff within twenty-four hours or during their next on-site visit. An interview with the facility administrator (FA) confirmed the program's practice and stated all youth are thoroughly screened at admission to identify all treatment needs. The FA further indicated, the program also provides comprehensive mental health and substance abuse evaluations on all youth within thirty days of their admission.

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

On the day of admission, each youth is referred for a Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation regardless of their results on the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). A review of five youth mental health and substance abuse records found each of the records contained a new evaluation completed within thirty days of admission. Collateral information such as psychiatric evaluations, interviews with family members and the juvenile probation officer (JPO) are also utilized in developing the evaluation results. All youth had the required screening/testing/assessments completed prior to the completion of the comprehensive evaluations. All evaluations were extremely thorough and included the methods of assessment, identifying information, screening procedures, presenting problem, family history, history of abuse/neglect/trauma, behavioral observations, physical health, developmental history, mental health, mental status exam, substance abuse history and treatment, social history, sexual history, vocational skills, independent living skills, strengths, needs, abilities, transitional planning, Diagnostic and Statistical Manual of Mental Disorders Version Five (DSM-5) diagnosis, summary of clinical impressions, and treatment recommendations. All evaluations were comprehensive and included information from prior evaluations including the psychiatric evaluation which was completed within fourteen days of the youth's admission. Three of the five youth's evaluations were completed by a licensed professional and all five were signed off by a licensed professional within ten calendar days. The evaluations were used in the development of each youth's Individualized Treatment Plan.

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 policy and procedures addressing treatment planning and reviews to include the treatment team member assignments of staff by job title. All five reviewed youth mental health and substance abuse records had documentation to show youth were assigned to a treatment team at the time of admission and a properly executed Authority for Evaluation and Treatment (AET) form in their individual healthcare record, unless the youth were eighteen years of age or older. The treatment team is comprised of the youth, therapist, case manager,

living unit representative, administration, recreation therapist and parent/guardian, if applicable. The recreation therapist and an education representative provide written input statements for each monthly treatment plan reviewed. Five youth mental health and substance abuse records were reviewed. Each of the youth had an Initial Mental Health and Substance Abuse Treatment Plan executed on the day of admission and an Individualized Mental Health and Substance Abuse Treatment Plan (ITP) completed within thirty days of admission. Further review of the of the five ITPs validated all youth were receiving group therapy, individual, and family counseling in accordance with their ITP. Each of the youth had co-occurring disorders and needed both mental health and substance abuse treatment. The reviewed documentation supports treatment is provided by a licensed mental health professional or a non-licensed mental health clinical staff working under the direct supervision of a licensed professional. Each of the five youth records contained a signed Consent for Substance Abuse Treatment and Consent for Release of Substance Abuse Treatment Records.

The treatment/progress notes were documented on a form which contained all the information in the Department's Counseling/Therapy Progress Note form (MHSA 018). A review of documentation and observations made by a review team member confirmed the mental health groups did not exceed ten youth in a group and the substance abuse groups did not exceed fifteen youth in a group. Observations of three youth's multidisciplinary treatment team meetings confirmed the treatment team consisted of the required individuals, and the ITP plan was reviewed. Five direct care staff were interviewed and asked if they, or other direct care staff, facilitate any mental health or substance abuse groups: three of the staff indicated no, two said yes if they are trained. Five youth reported they were participating in groups and receiving any specialized therapy. Two youth specifically mentioned their participation in the grief and loss group, Voices, and Impact of Crime. An informal interview with the regional clinical director, validated the program's practice of treatment service provision.

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

Five youth mental health and substance abuse records were reviewed. All records contained an Initial Mental Health and Substance Abuse Treatment Plan completed on the day of admission, and an Individualized Treatment Plan (ITP) completed within thirty days of admission. Both the initial and the individualized plans were documented on a form which includes all the elements listed in the Department's form. Each of the initial plans included a goal for youth to obtain a psychiatric evaluation within fourteen days. A review of the ITP is conducted every thirty days, and the ITP Review form contained all elements required in the Department's form. The plans were signed by all members of the treatment team to include the parent/guardian if they participated by telephone. All plans were signed by the licensed mental health professional within ten days of completion. Each plan was mailed out to the parent/guardian with a request to sign the signature page and send back to the program. None of the plans had a signature page

returned from the applicable youth's parent/guardian. A review of the ITP is conducted every thirty calendar days and the review form contained all elements required in the Department's form. The required elements included documentation of a current DSM-5 diagnosis and symptoms, mental health and /or substance abuse treatment goals with documentation of progress made by the youth in meeting each treatment goal, and any changes in mental health and/or substance abuse treatment methods or interventions. All five ITPs included the most recent psychiatric evaluation recommendations in which two were prescribed medication at the time of admission and one was prescribed medication post admission. All three youth had a goal on their ITP pertaining to psychotropic compliance. A review of progress notes determined youth are receiving treatment services as prescribed on their ITP.

A total of three closed youth mental health and substance abuse records were reviewed. Each contained a completed discharge summary signed by the youth and therapist. The discharge plan was documented on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form (MHSA 011). Documentation confirmed the discharge summary was discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. None of the youth were at risk for suicide at the time of release. The summary form considered the services needed for daily maintenance of the positive improvement in skills made by the youth during treatment. A release form was signed by parent/guardian in one applicable record. The remaining two youth were transported home by their JPO. All three records revealed a copy of the discharge summary was reviewed and provided to all parties at the time of discharge. A copy of the summary is maintained in each closed youth record.

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 has a written plan for the delivery of treatment services. Mental health overlay services (MHOS) are the primary clinical treatment component used within the program to address the mental health and substance abuse needs of the youth. The program is currently licensed by the Department of Children and Families (DCF) under Florida Statutes, Chapter 397 to provide outpatient substance abuse treatment services to all youth with a co-occurring disorder. A review of documentation and an interview with the facility administrator (FA) and clinical director validated the program offers MHOS services to youth in this program which include but are not limited to screening processes, clinical assessments and evaluations, treatment planning and review, daily therapeutic activities, behavior modification, and psychiatric services as needed. The program has a licensed mental health professional on-site at least five days a week. Mental health clinical staff are on-site seven days a week and the counselor case load does not exceed ten youth. Each of the five reviewed youth mental health and substance abuse records had documentation to verify the provision of specialized services in accordance with the program's contract with the Department. Additionally, the program contracts with a company to provide the services of a certified behavior analyst (CBA) when needed. Five youth mental health and substance abuse records were reviewed and one youth were applicable for receiving services from the CBA. Documentation from the CBA showed the CBA has been to the program several times a month since April 2019; however, due to proprietary information from the CBA subcontractor, weekly chronological notes are not included in the youth records. A behavior plan by the CBA was contained in the one youth IHCR which was reviewed and applicable for CBA services. The remaining youth were not applicable or in need of the CBA's services. The program also has an agreement with a licensed psychologist to

provide services as needed; however, they have not utilized the psychologist's services during the annual compliance review period. During an interview with the facility administrator, it was confirmed the practice observed by the review team.

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

The program maintains an agreement for professional services with a licensed psychiatrist who is designated to oversee the psychiatric services in the program. Services include the provision of psychiatric evaluations, participation in treatment planning, and supervision of the treatment for youth who are prescribed medications, in coordination with the designated mental health clinician authority (DMHCA) and the multi-disciplinary treatment team. The psychiatrist is a medical doctor with experience and training in child/adolescent psychiatry and licensed in the State of Florida with an expiration date of January 31, 2021. There is also an advanced practice registered nurse (APRN) to serve as a back-up to the psychiatrist, as needed. The APRN has an active license in the State of Florida expiring on July 31, 2020. The APRN works under the clinical supervision of the psychiatrist, as specified in a copy of the collaborative practice protocol maintained on-site. The psychiatrist is available to the APRN by telephone when not physically available to be at the program. A review of weekly sign-in logs for the last six months revealed the psychiatrist has been on-site every week for a minimum of two hours except for one week where the APRN provided services. The program's practice is to refer every admitted youth for a psychiatric evaluation within fourteen days of admission. A review of five youth mental health and substance abuse records indicated an evaluation was completed within fourteen days on each youth. The initial evaluation was a form developed by the program and included all elements required by the Department in addition to page three of the Clinical Psychotropic Progress Note; however, the form was not clearly identified as an Initial Diagnostic Interview. A review of five youth mental health and substance abuse records indicated an evaluation was completed within fourteen days. Two of the five youth were admitted with and continued psychotropic medication. One of the five youth was referred to the psychiatrist post admission, re-evaluated, and placed on medication. All three records for youth on medication documented medication evaluations and management conducted every thirty calendar days after the initial evaluation placing or continuing them on medication. While on-site weekly, the psychiatrist/APRN meets with at least one member of the treatment team to review the status of all youth evaluated and/or prescribed psychotropic medication. Sign-in sheets and minutes were present for all meetings which took place within the last six months. An interview with the psychiatrist confirmed the program's practice.

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

The program has a policy and written plan to describe the program's procedures for prevention of suicide. The plan is an attachment to a policy. The plan was signed by the facility

administrator (FA) and previous designated mental health clinician authority (DMHCA) on July 2, 2018. The plan was updated and reviewed by the FA on June 24, 2019 and the new DMHCA on July 15, 2019. The plan included but was not limited to the program's process of identification and assessment of youth at risk of suicide, staff training, levels of supervision, referral process, communication, notification, documentation, immediate staff response, and the review process. During an interview with the FA, it was stated the program uses a minimum of four assessments to identify youth at risk for suicide; one of which is an Assessment for Suicide Risk. Additionally, regardless of screening results, each youth receives a comprehensive evaluation within thirty days of admission.

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

The program has a policy and procedures addressing suicide prevention services which include the administration of an Assessment of Suicide Risk (ASR) to all admitted youth, regardless of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) results. Five youth mental health and substance abuse records were reviewed for verification of program practice. All records contained a completed ASR on the day of admission; in addition, to a MAYSI-2. None of the five youth required further assessments on the MAYSI-2 for being at risk for suicide; however, all youth were referred for further assessment and evaluation based on reviewed documentation and/or observations.

Four of the five youth in the sample made gestures or threats of self-harm post admission. Three were immediately placed on a constant level of precautionary observation (PO) and referred for an ASR. An ASR was completed on the same day for all three youth. One youth was in controlled observation and made suicidal gestures which was immediately moved to secure observation (SO) status by staff. A referral was submitted to the mental health staff on February 18, 2019, at 6:38 p.m. A review of the secure observation log sheet indicated youth was released from observation on the same day at 7:36 p.m.; however, the initial ASR was not completed until February 19, 2019, at 10:30 a.m. The program provided the review team a picture copy of a text message to verify the clinician texted communications with the facility administrator regarding the youths' SO status ending. The text message was sent on February 18, 2019, at 8:02 pm; however, the log sheets documented the youth was already removed from SO. According to Florida Administrative Code 63N, requires a youth released from SO status be stepped down to a minimum level of close observation. A review of documentation indicates the program was not in compliance with this requirement as the youth was stepped down from SO and placed directly to standard supervision. A reviewed ASR was not completed until February 19, 2019, which indicated upon observation of the youth behavior, staff immediately placed the youth on a constant level of precautionary observation.

One of the four youth was placed on precautionary observation (PO) on April 13, 2019 and referred for an ASR. The youth's ASR indicated a Follow-Up ASR would be completed in twenty-four hours; however, on the same day the youth's behavior escalated and staff placed youth on SO status. A Follow-Up ASR was not completed until April 15, 2019, which outlined youth placement on PO and escalation SO status. However, the initial placement into SO occurred on April 14, 2019, at 9:56 pm. A review of the observation log sheet indicates the youth was removed from SO on April 14, 2019 at 6pm, and a Follow-Up ASR completed on April 15, 2019, at 9:05 am. The program indicated the regional clinical director met with the youth on April 14, 2019, to release youth from SO status and step down to constant supervision; however, this event was not documented until the completion of the Follow-Up ASR on April 15th. The program did not provide the review team with documentation supporting completion of handwritten assessments prior to electronic entry. During the annual review cycle the program only had two examples of youth placed on SO status. Both examples contained documentation of staff completion of a Health Status Checklist, search of the youth, and inspection of the room.

The parent/guardian and juvenile probation officers were notified of each youth's potential suicide risk. Three of the four ASRs were completed by the licensed mental health professional and the remaining one was conducted by a non-licensed mental health clinician. The ASR completed by non-licensed staff was reviewed and signed by a licensed mental health professional. A review of the non-licensed staff training record confirmed they received all required assessment training in the 2017 calendar year. All youth on PO remained on PO until an ASR or Follow-Up ASR could be completed to discontinue PO. Documentation revealed the youth's activities was not restricted while on PO. A logbook review for dates, the youth were placed on PO included the time youth were placed on precautions, the time youth placed on close supervision, and the time youth returned to standard supervision. A review of the Juvenile Justice Information System revealed all alerts were opened and closed, as required. Five interviewed staff were aware of the two suicide response kits location and program's procedures in an event where a youth expresses suicidal thoughts. Five youth previously placed on SO or PO status were interviewed. Each confirmed they were never left alone while on observation and staff was always present.

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 suicide precaution observation logs for four youth placed on precautionary and/or secure observation were reviewed. Each log included the designated safe housing areas, necessary restrictions, and observations of youth were documented every thirty minutes. Warning signs were documented and mental health clinical staff and administration were notified. Each log was reviewed and signed by the shift supervisors. Mental health clinical staff reviewed and signed the logs daily. The program uses the Department's form and each are printed in different colored paper for staff to easily distinguish between levels. Five youth previously placed on suicide precautions were interviewed. Each confirmed they were never left alone while on observation and staff was always with them.

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.	

All five reviewed in-service staff training records had documentation of at least six hours of training in suicide prevention. All staff training was documented in the Department's Learning Management System (SkillPro). Mock suicide and mental health emergency drills were reviewed for the last four quarters during the period of July 2018 through June 2019.A drills was conducted quarterly on each shift. The program conducted a total of nineteen drills during this time frame. Drill participation was reviewed for ten random staff, the results show all ten staff participated in at least one drill each quarter. All mock drills included emergency response to a suicide attempt or self-inflicted injury. Drills included methods for contacting other program staff, medical personnel and emergency medical services in addition, to the use of a first aid kit and/or suicide response kit. Each staff participated in at least one drill which included the demonstration of cardiopulmonary resuscitation (CPR) techniques. The program has two suicide response kits, one outside of the medical clinic and master control. Both kits contained wire cutters, suicide rescue tool, needle nose pliers, and a one-way CPR mask. During an interview with the facility administrator, it was indicated drills are scheduled monthly on each shift and attempts are made to ensure each staff member participates in one drill every quarter.

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 plan detailing crisis intervention procedures which includes notification and alert system, means of referral to include youth self-referral, communication, supervision, documentation, and review. The plan was signed on July 2, 2018 by the facility administrator (FA) and the former designated mental health clinician authority (DMHCA). The plan was updated by the FA on June 24, 2019 and the new DMHCA on July 15, 2019.

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.	

A review of five youth mental health and substance abuse records were reviewed and only one youth had a crisis assessment completed since the last annual compliance review. The program had two other examples of a completed crisis assessment to provide for review. None of the three youth were in psychological distress prior to or when the assessments were completed. One youth received an assessment after returning from the hospital after childbirth. The program wanted to be proactive in assessing her needs. The second youth was a witness to an alleged Prison Rape Elimination Act (PREA) allegation and the third youth was the reported victim. Two of the assessments were completed within the required two-hours. The third youth was released prior to the annual compliance review; therefore, the program could not provide the reviewer with a copy of the referral to confirm the referral was made immediately after the allegation occurred; however, the assessment was completed within twenty-four hours. The program utilizes the Department's form which two of the assessments were conducted by a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional trained to conduct assessments. The third assessment was completed by a licensed mental health counselor. None of the examples required notifications to additional parties, a logbook entry, or an alert in the Department's Juvenile Justice Information System (JJIS) as the three youth were all recommended to remain on standard supervision. There were no youth who received an off-site crisis assessment.

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

The program has an emergency care plan which was signed by the previous designated mental health clinician authority (DMHCA) and facility administrator (FA) on July 2, 2018. The plan was recently reviewed and signed by the FA on June 24, 2019 and the new DMHCA on July 15, 2019. The plan addresses immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance services, transport for emergency mental health evaluation and treatment under Chapter 394 FS (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397 (Marchman Act), documentation, training to include mock drills, and review.

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

The program did not utilize a Baker or Marchman Acts during this annual compliance review period; therefore, this indicator is 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 policy and procedures which outline the provisions and responsibilities of a designated health authority (DHA). The program utilizes an independent contractor agreement with a licensed medical doctor (MD) who serves as the DHA and holds an unrestricted clear and active license to practice medicine in the State of Florida, with specialty training in internal medicine, expiring on January 31, 2021. A review of the past six months of documentation, confirmed the DHA is on-site at least once a week for two hours. After reviewing the DHA contract, sign-in and sign-out logs, interviews, and other supporting documents; it was determined the DHA is available twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and the coordination of off-site care. The program has a contract with a licensed MD for coverage in place for scheduled absences, emergency services, and vacations. The backup MD has an active license to practice in the State of Florida with a specialty in family practice expiring on January 31, 2021. The program does not utilize an advanced registered nurse practitioner (ARNP) and/or physician assistant. During an interview with the DHA, it was verified the DHA is responsible for communication with the nursing staff regarding the youth's medical needs, availability by telephone for consultation, emergency care, and coordination for off-site care twenty-four hours a day. The DHA reported there were no concerns regarding the medical care provided to the youth.

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

The program has policies and procedures which regulate the delivery of health-related services to youth. An annual review of youth health-related services policies and procedures was conducted in June 2019. The policies and procedures were reviewed, approved, and signed by the designated health authority (DHA) and the facility administrator (FA) on June 19, 2019. The DHA and FA also conducted an annual review of the nursing protocol manual on June 19, 2019. After approval, all medical staff reviewed and signed in acknowledgment on the signature page the program's policy, procedures, and the nursing protocol manual. There were no blanket protocols. The policy related to psychiatric services was also signed by the psychiatrist on June 24, 2019. A review of the hire dates for the nursing staff documented, there were no medical staff hired in the past six months. A review of the above documentation confirmed all current staff properly signed and acknowledged the new standards, as required.

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

The program has a policy and procedures to address parental consent which requires an Authority for Evaluation and Treatment (AET) to be signed by the youth's parent/guardian. Five youth Individual Healthcare records (IHCRs) were reviewed and each contained an AET. The AET form is signed by the parent/guardian and serves as informed consent for non-invasive

medical procedures or for minor illnesses requiring over-the-counter (OTC) medications which can be treated by healthcare staff. One youth IHCR contained an original AET and four youth IHCRs contained an Authority for Evaluation and Treatment stamped as 'copy' authorizing specific treatment while in the custody of the Department. These AETs are valid until the youth's eighteenth birthday. One youth turned eighteen years of age while in the program and signed a new AET in accordance with policy. In all five IHCRs, there were copies of completed parental notifications which were maintained behind the AET in the IHCRs. There were no applicable youth under the care of the Department of Children and Families (DCF). During an interview with nursing staff, it was confirmed adherence to the program's policy of validating all AET's prior to youth's admittance to the program. If an AET is found to be invalid, nursing staff will contact the assigned juvenile probation office (JPO) to coordinate obtaining a new AET.

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

The program has a policy and procedures to address parental notification. The policy requires notification to the youth's parent/guardian of any new medications, off-site referrals, medical emergencies, and additional informed consent for special circumstances such as hospitalizations, surgeries, or other invasive procedures. If a youth is prescribed psychotropic medication, the policy also requires the third page of the Clinical Psychotropic Progress Note (CPPN) to be sent through certified mail to the youth's parent/guardian. The policy also requires the nurse to verify the youth's immunizations upon admission, update the information in the Department of Juvenile Justice Immunization Tracking record, and review the immunization record on the nursing chronological admission note. The program maintains a list of over-the-counter (OTC) medications approved by the designated health authority.

A review of five youth Individual Healthcare Records (IHCRs) found the program sends a list of over-the-counter (OTC) medications approved by the designated health authority (DHA) to each parent/guardian with a welcome letter and a request to return the signed consent form. All the IHCRs contained documentation of parental notification for OTC medications beyond those covered by the Authority for Evaluation and Treatment (AET). Five youth were applicable for parental notification for new medication and the reviewed documentation confirmed both verbal consent was documented in the progress notes and written notification was mailed to the parent/guardian in each case. Notifications were also sent, as needed for issues such as the discontinuation of medication, changes in condition/medication for youth with chronic conditions, non-routine dental procedures, and off-site medical treatment. Three of the five youth IHCRs reviewed were prescribed psychotropic medications and in each case, the proper Departmental forms were utilized in approving consent for treatment. One youth was eighteen years of age and provided consent for treatment which was documented on the Department's form. All three IHCRs reflected telephonic consent which was witnessed by staff and a written follow-up copy of the CPPN outlining the medication prescribed, reasons for the medication, and an Acknowledgement of Receipt request for each CPPN was mailed, as required. All five youth IHCRs reflected vaccinations were verified within thirty days of the youth's admission. Each record contained a copy of the youth's immunization record received from the Department, the Florida Shots website, and/or school records. There was no evidence of a youth's parent/guardian refusing to consent to a vaccination for medical reasons and/or any exemptions due to religious beliefs since the last annual compliance review. In all instances, medication was not given to youth until the proper consent was received. All telephone calls and/or attempts were witnessed by a staff member. There were no youth applicable for notification to the

Department of Children and Families. During interviews with nursing staff. It was reflected parent/guardians are contracted by phone to inform them of any new medication, emergent care, or as a situation warrants. Written parental notification is completed within twenty-four hours.

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

The program has a policy and procedures to address healthcare admission screening which requires the completion of a Facility Entry Physical Health Screening (FEPHS). Five youth Individual Healthcare Records (IHCRs) were reviewed. Each IHCR contained a FEPHS form completed by a registered nurse, on the date of the youth's admission to the program. One of the reviewed five youth IHCR contained a change of custody. A FEPHS re-screen was completed for this youth on the date the youth was readmitted into the program. The designated health authority (DHA) is notified of all youth admitted to the program. Additionally, the admission progress notes in each record documented the completion of the FEPHS. All records reflected chronological progress notes for consent and result of pregnancy screening for sexually active females. According to nursing staff interviews, the nursing department completes all FEPHS on the day of admission. If a change in custody occurs, a FEPHS re-screen is completed for the youth by the nursing department. If the youth returns when the nursing staff is not present, a staff member conducts the FEPHS and a nursing staff member reviews it within a twenty-four hour period.

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

The program has a written policy and procedures to address each youth's orientation to healthcare services. The orientation covered all required topics, including how to access sick call, what constitutes an emergency, how medication is administered and possible side effects, the right to refuse care and how it is documented, and notifying staff of all allergies, chest pain, and/or extreme shortness of breath. The orientation also covers what to do in case of a sexual assault and the non-disciplinary role provided by medical staff. Five youth Individual Healthcare Records (IHCRs) were reviewed. Each IHCR documented youth received an orientation to the program's healthcare services on the day of admission by a registered nurse. The orientation for each youth covered all the required topics to include the review of the youth's Health Education Form. Each orientation form was signed by the youth acknowledging receipt of the healthcare orientation.

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 has a policy and procedures which requires notification of the designated health authority (DHA) when a youth is admitted into the program with a known or suspected chronic condition not requiring emergency treatment. Five youth Individual Healthcare Records (IHCRs)

were reviewed. Each IHCR reflected telephonic notification of the (DHA) of the youth's admission into the program. During admission, none of the youth presented a condition requiring an emergency response. All records reflected notification documented in the youth's chronological progress notes/ IHCRs. During an interview with the nurse, it was reported the DHA is notified of a youth's arrival at the program upon admission. The nurse completing the admission is responsible for the notification. Referrals to the DHA are documented on the Facility Entry Physical Health Screening (FEPHS) form and the youth are placed on the DHA list.

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

The program has a written policy and procedures to address the completion of Health-Related History (HRH) upon admission to the program. Five youth Individual Healthcare Records (IHCRs) were reviewed and each record contained a new HRH. In all cases, the HRH was completed by a registered nurse (RN) within seven days of the youth's admission to the program. All reviewed IHCRs validated the HRH was completed prior to the completion of the youth's Comprehensive Physical Assessment (CPA). There was clear documentation of the designated health authority (DHA) reviewing each HRH. The proper Department forms were utilized for both the CPA and HRH documentation. During an interview with the nursing staff, it was reported medical staff completes the HRH upon admission, annually prior to the CPA, and as needed. One youth left the custody of the program due to an arrest, the HRH was updated when the youth was readmitted to the program.

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

The program has a policy and procedures which requires the completion of a new or updated Comprehensive Physical Assessment (CPA) form prior to the youth participating in any strenuous activity. Five youth Individual Healthcare Records were reviewed. Four youth IHCRs contained a new CPA for each youth with one youth possessing a current CPA at the time of admission. In all IHCRs reviewed, the CPA was completed by the designated health authority (DHA) within seven calendar days of each youth's admission to the program. Each CPA documented the youth's medical grade and was completed in accordance with the Department's requirements. In all five IHCRs, the medical doctor deferred the Tanner stage along with the rectum exam portion of the evaluation due to no negative indicators. Each CPA was filled out correctly. All CPA's confirmed tuberculin skin tests (TST) were conducted and youth were not placed in general population until results were assessed by the program's DHA. Reviewed documentation also supported the Department's Problem List for five applicable youth were also updated, as required. During an interview with the nursing staff, it was confirmed the CPA form is completed within seven days of a youth's admission, and annually thereafter. Nursing staff also confirmed gynecological exams are routinely completed for all youth at the program.

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI) and human immunodeficiency virus (HIV). A review of five youth Individual Healthcare Records (IHCRs) confirmed each youth self-identified as sexually active which resulted in a clinical screening and evaluation for STIs utilizing the Department's Sexually Transmitted Infections Screening form. Additionally, each youth was referred to the designated health authority (DHA) for further evaluation resulting in further testing which was ordered and completed for all five youth. Test results were filed in the youth's IHCR in the laboratory results sections and were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. The program utilizes the "Metro Wellness" on-site provider to provide pre-counseling, testing, and post-counseling. Current 500/501 HIV training certification certificates were reviewed and acquired for the provider facilitators. Five youth ICHRs were reviewed. All youth were offered the opportunity to receive counseling and testing for HIV. All youth who consented to receive counseling and testing signed the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. A review of five youth records validated all youth received pre-counseling, testing, and post-counseling services by the contracted provider and each youth's Health Education Record section was updated in the respective IHCR to reflect the HIV services provided. Test results were placed in a sealed envelope marked 'confidential' with the youth's name, program name and address, date of test, and the youth's signature documented on the outside of the envelope and filed in the laboratory test section of the IHCR. The program does not include HIV status as part of the internal alert system. Five interviewed youth stated they could request a HIV/AIDS test.

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

The program has a policy and procedures in place to provide a means for all youth including youth in confinement or controlled observation, to submit sick call requests and to be treated appropriately through response time and documentation. Sick call hours are from 7:30 a.m. through 8:00 a.m. and 2:30 p.m. through 3:00 p.m., seven days a week and are posted above the sick call box at the nurse's office. Sick call forms are accessible to youth and are located on the wall in front of the nurse's office. Sick call is conducted daily by a registered nurse (RN). The youth in confinement are questioned daily of any health complaints they may have; however, none of the youth reviewed were placed in confinement or did not have enough time in confinement to be applicable. A review of t additional confinements found, none of the youth reviewed were in confinement long enough to be applicable. If a nurse is not on-site for a sick call, the designated health authority (DHA) is responsible to ensure the sick call is handled within four hours of the submitted complaint. All sick calls are documented on the sick call index and the sick call referral log when referrals are necessary and all progress notes with regard to this, are in compliance. Three of the five youth were applicable for completed sick call requests.

All three youth were seen within four hours of submitting the request. All three youth had a sick call request form completed by the nurse in the progress notes in reverse chronological order. There were no applicable youth with three or more sick call complaints in a two-week period. No youth submitted a sick call during the annual compliance review; therefore, no sick calls were observed. Five interviewed staff indicated sick call is held once a day. Five Interviewed youth indicated they are allowed to see a dentist and doctor when needed and medications are administered by the nurse. Additionally, one of the five youth was applicable for seeing a gynecologist and was given this opportunity. An interview with five staff indicated, sick call and medication administration is performed by a RN and each of the staff can call 911 when necessary.

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 policy and procedures in place to provide episodic care, including basic first aid procedures and interventions. Emergency medical and dental care is available twenty-four hours a day. All healthcare and non-healthcare staff can call 911 and have current certifications in first aid and basic cardiopulmonary resuscitation (CPR),automated external defibrillator (AED) training, and epinephrine auto injector training. The program has an AED located on the wall outside of the nurse's office located in the multi-purpose room. The AED contains automated instructions on usage and written instructions inside of the unit. A review of the AED found the battery was last changed in May 2017 with an expiration date of July 2022. The AED shock pads were changed in April 2019 with an expiration date of September 2021. The nurse performed an appropriate self-test of the AED for the annual compliance review team member. AED checks were reviewed since the program's last annual review and were conducted monthly. A list of emergency numbers is stored inside the cabinet in the nurse's office and is inaccessible to youth.

Episodic care is provided by the nurse and documented in the progress chronological notes and tracked in the episodic log. There were no reports of necessary first-aid treatment.
A first aid kit is stored in master control, one for each of the two transportation vehicles which are stored in master control until a transport occurs, one in the Cherish dormitory, and one in the Treasure dormitory. There is a suicide kit located in master control. The first aid kits and suicide kit are each fully stocked with the approved contents and each are monitored by the nurse. The nurse checks the kits monthly and tracks the audits on the log sheet. There were no incidents where the program had to administer emergency medical or dental treatment. Progress notes addressing non-emergent care provided were in reverse chronological order and compliant with expectations. The first aid log sheets had multiple overwrites without strike throughs and initials of the person correcting them; however, the documentation was legible and meets the requirements. The episodic logs were reviewed for six months and compared with on-site and off-site events in the matching youth's individual health care record (IHCR). Medical drills were reviewed for the previous one year period. The drills are conducted quarterly on each shift and include CPR, at least annually. The automated AED was brought to the drills by staff; however, there was no documentation the actual use of the AED was necessary. Steps covering how and when to use the AED were covered in one of the mock drills. One staff did not participate in the necessary drills; however, this staff is no longer employed with the program.

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

The program has a policy and procedures in place to provide timely referrals, coordination, and documentation of medical services to off-site health providers for youth with emergent or non-emergent needs. One of five records reviewed was applicable for off-site health services. The parent/guardian was notified of the need for services, a summary of the services was filed in the youth's individual health care record (IHCR), the designated health authority (DHA) reviewed the findings of the off-site provider, and coordinated the follow-up care necessary for the youth. There were no other youth available for episodic off-site care upon inquiring of additional applicable youth since the last annual compliance review period.

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

The program has a policy and procedures in place to ensure youth with chronic conditions receive regular evaluations and the necessary follow-up for care. Five youth Individual Healthcare Records (IHCRs) reviewed were applicable for having a chronic condition. Each of the youth were administered periodic evaluations at least every three months, and prior to the renewal of prescription medication. Documentation supported youth on psychotropic medication were seen on a thirty-day basis. The IHCR for each of the youth was reviewed to confirm documentation in the chronological notes. Two of the IHCRs reviewed were a medical grade three and the remaining three records reviewed were a medical grade five. All five youth were placed on the chronic illness list, received a specialized treatment plan, had their periodic evaluations tracked and documented in each of their IHCRs. The treatment orders for the youth are typed and legible. During an interview with the designated health authority (DHA), periodic evaluations are completed every two months and a tracking system is utilized to update the problem list and progress notes. One youth was seen off-site for health services and the services were documented on the Summary of Off-Site Care Form and filed in the IHCR progress notes. The one applicable youth was seen by the DHA for off-site services and a follow-up. There was no lapse in services for any youth on-site or off-site. The problem list was updated for each of the five IHCRs reviewed and applicable for chronic conditions. The DHA indicated periodic evaluations are completed every two months and a tracking system is utilized through the problem list update and progress notes.

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

The program has a policy and procedures in place for medication to be received, stored, inventoried, and provided in a safe and effective manner. Only medications from a licensed pharmacy with current, intact labels are accepted into the program. The program obtains medications from a pharmacy vendor off-site which has a modified class II pharmacy permit. Currently, there are no youth in the program with prescribed narcotics. All medication is in a

separate and locked medicine cart which is maintained in the nurse's office inaccessible to youth. During an interview with nursing staff, it was reported if the program have a youth prescribed a narcotic; the program has a separate location for these medications which is double locked. No oral medications are stored with injectables or topical medications. The program now has a separate refrigerator in front of master control which is marked biohazard and locked for medications requiring refrigeration. There was no medication which required refrigeration in the refrigerator at the time of the annual compliance review. Syringes, sharps, and over-the-counter (OTC) medications are secured in a locked cabinet in the nurse's office. All medication is documented in the Individual Health Care Record (IHCR) of the youth and on the standard Medication Administration Record (MAR). Each entry is initialed by staff. The program used the Department's MAR. Youth have start and stop dates for medications and receive medications as ordered in a timely manner. Weekly side effects monitoring is documented on the MAR and the Six Rights of Medication Delivery/administration is maintained. All refusals of medication by youth are documented on the MAR. There were no standing orders, emergency treatment orders, or as needed orders for psychotropic medications. Three of the five IHCRs reviewed were applicable for receiving medications. Youth on medication at admission had the medication documented on their admission record and placed on the MAR for administration. Continuations and discontinuation of medications are reviewed by the designated health authority (DHA) and parent/guardians are notified. All youth had a current and valid order for the medications. Six youth in a medication pass was observed during the annual compliance review. Each youth understood the process to state their name, any allergies they have, the name of the medications they are taking, the nurse to sweep their mouth with a swab to check for pills/tablets, and the youth to cough and show their hands and sleeves to the nurse. The night supervisor, a non-healthcare staff administers medications when necessary and is trained to do so by the registered nurse (RN). Weekly side effects are monitored by staff daily and only the RN provides medication unless necessary on night shift. Only the night supervisor provides medications on night shift. Any refusals of medication are documented on the MAR. There were no youth placed on restricted housing who required medications. Stericycle is the company contacted by the program to dispose of expired medications or biohazard waste monthly. Five interviewed youth indicated medications are administered by the nurse. Five interviewed staff indicated medication administration is performed by a RN.

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

The program has a policy and procedures to secure and inventory any sharps or stock medications with a perpetual weekly inventory in a descending count as they are utilized and disposed. The policy is to keep these items locked in a cabinet within the nurse's office. The program does not currently have any youth requiring controlled substances; however, the program does have a separate perpetual inventory form and a location to store the medications behind double locks. The double-locked medication bin was empty upon physical review of the medicine cart by the review team. The inventories were reviewed for the previous six months. The program does not currently have youth requiring controlled substances. The nurse inventories medications weekly. If there is an error, a strike-through is made and initialed by the staff correcting the error. There were no medication administration errors found by the review team. The nurse supervisor also ensures inventories and discrepancies are handled with corrective action plans. An observation of three sharps, three over-the-counter (OTC) medications, and two youth medications found a discrepancy the program had one bottle of

rubbing alcohol and the inventory indicated there was none. The discrepancy was immediately corrected in the presence of the review team. There were multiple overwrites noted in the sharps inventory log for January, March, and April 2019 as well as OTC medications; however, they were all legible. Stericyle is the company which disposes of expired medications and biohazard material monthly called by the program and as needed. The program stores the receipt from the disposal in a binder for medication management. The program had a separate refrigerator for medications; however, the refrigerator was not labeled biohazard and was not secured. The program corrected this by adding a lock to the refrigerator and labeling it while the review team was on-site.

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 a policy and procedures in place to prevent, contain, treat, and report requirements related to infectious diseases as required by Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC). The procedures includes risk assessment and methods of compliance which is located in master control and available to all staff. The procedures was last reviewed and signed on June 29, 2019 by program management. The program includes pre-service and in-service training for all staff and education for the youth at intake; and as needed inclusive of hand washing, preventative measures of communicable diseases, and infection control.
The infection control procedures for the program include all necessary elements required. Staff have access to protective equipment and follow standard universal precautions. The program has a policy to administer a needle stick post-exposure evaluation for staff if they are exposed. There were no instances in which the program was required to report an infectious disease to the local health department, CDC, or Central Communications Center (CCC). Exposure plans are reviewed with staff upon hire and annually during pre-service and in-service training.

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

The program has a policy and procedures in place to provide access to prenatal care for all pregnant youth and for health education to be provided to youth and staff. There is a nursing protocol and treatment plan in place for pregnant youth. Prenatal care begins immediately after a youth is determined pregnant. This care continues through discharge, transfer, and postpartum. In the reviewed Individual Healthcare Records (IHCRs), documentation supported a licensed nurse provided in-service education annually to non-healthcare staff which includes monitoring and observation. The only staff who did not complete the training is no longer employed at the program. The designated health authority (DHA) provides a medical evaluation of the pregnancy every thirty days. There was one youth applicable for prenatal care since the last annual compliance review. The youth was placed on alert for diet and provided double portions of food to ensure the proper nutrition. The youth IHCR reviewed was monitored daily for danger signs during pregnancy and evaluated monthly by the DHA. The youth delivered the

baby and the parent/guardian of the youth took custody of the baby for now. Observation of the applicable youth found the youth did not sleep on upper bunk beds, was provided with all required education topics for the pregnancy, and given a plan of care for post-birth on April 4, 2019. The documentation in the IHCR of this youth was consistent with these requirements. The program has a policy to provide additional testing for high-risk pregnant youth and for all pregnant youth to receive a human immunodeficiency virus (HIV) test, unless the youth refuses and signs a waiver which is filed in the IHCR. An outside health group provides the on-site HIV testing as well as pre-counseling and post-counseling.

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 policy and procedures addressing youth supervision. The policy for supervision is one staff to six youth during the daytime and one staff to twelve youth at nighttime. Both living units had the daily schedule and activity schedule posted. An interview was conducted with the assistant facility administrator (AFA) and a floor staff member regarding procedures when the youth count cannot be reconciled. Both the AFA and floor staff member provided specific instructions on how to handle discrepancies and recounts appropriately. Observations conducted throughout the four-day annual compliance review period confirmed staff consistently maintained active supervision of youth during daily activities such as school, large muscle activity/recreation activities, groups, line movements, and meals. Staff searched youth before all movements of youth. Master control was also observed calling formal head counts throughout the duration of the annual compliance review. Program staff were observed adhering to the daily activity schedule and providing active supervision. Youth were also observed engaging in recreational and leisure activities in classrooms, the multi-purpose room, and in the living units. Staff were observed within the required ratio of one-to-six during daytime activities and positioning themselves at all times to be able to closely observe the youth.

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 clearly written policy and procedures regarding the behavior management system (BMS) called the Positive Performance System (PPS). There is a PPS tracker posted on both living units. Explanations on how to earn varying incentives were also clearly posted on the walls in both living units. An interview with the program’s regional compliance specialist revealed all education staff are trained on the PPS. A review of ten staff training records (five of each pre-service and in-service staff) reflected staff are trained on the behavior modification system. There have been no changes in the BMS since the last annual compliance review. An interview with the facility administrator (FA) reflected the treatment team is responsible for the development, implementation, and on-going maintenance of the BMS for each individual youth.

Five case management records were reviewed. All five records had documentation to support youth received an orientation to the BMS, received a copy of the youth handbook, and discussed the positive and negative consequences for behaviors. All records reflected consistent implementation and oversight of the BMS.

The BMS included all required information including how to maintain order and security, promotion and protection of youth rights, positive and negative consequences, constructive disciplinary actions, positive reinforcement, recognition of accomplishments, socially acceptable means, a process for explaining sanctions, an opportunity for the youth to explain themselves, an opportunity for discussion, reasonable reparations, alternative behaviors, and promotion of positive resolution. The program accomplishes these tasks by having special treatment teams with documentation to reflect the required information above and providing expectations on the PPS. An informal interview was conducted with the recreational therapist who explained the four-to-one positive-to-negative ratio is met with daily, weekly, monthly, and Terrific Tuesday incentives. Some incentives for Terrific Tuesdays include snacks, games, and movies. An individual behavior plan is developed, as needed, and the plans are developed around positive behavior in daily activities to minimize separation from the population. Through observations of the physical plant during the annual compliance review, it was evident staff are promoting a positive environment. Staff were observed having active conversations, greeting youth warmly, and asking them questions of concern when something seemed wrong. Five youth were interviewed. All of the youth stated they are offered a variety of incentives and rewards used as positive reinforcement. Five staff were interviewed about the BMS. All staff were able to discuss the point system, incentives to include spa days and extra food, and consequences of the BMS. All staff confirmed they cannot take things away from youth as a consequence.

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

The program has a policy and procedures on the comprehensive and consistent implementation of the behavior management system (BMS) and training for staff on the understanding and implementation of the BMS. The policy covers protocol where staff provide feedback regarding implementation of the BMS. Position descriptions specified the required qualifications of staff whose job functions include implementation of the BMS. All required parties were involved in the development, implementation, and on-going maintenance of the BMS. The BMS includes a process wherein staff explain to the youth the reason for any sanction imposed prior to the end of the staff member's workday. The program does not utilize room restriction as part of the BMS. The BMS does not include increased length of stay, denial of youth basic rights, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement. An interview with facility administrator (FA) indicated the program utilizes a positive performance system (PPS) as the program's BMS. Rewards are monitored daily, weekly, and monthly and are developed by the youth advisory board. The FA states staff models a four-to-one model of rewards to consequences and peer support helps to ensure the practice is on-going. Youth are able to earn points daily and can move up to the next level by earning multiple positive days. Consequences can include a loss of points or a special treatment team. All five interviewed youth reported they understand the BMS. Five pre-service and five in-

service staff training records were reviewed, and all documented training in the BMS. Records also showed the education staff were jointly trained on the utilization of the BMS during school.

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

The program has a policy and procedures addressing the supervision of youth. The program currently has thirty-two cameras, and all thirty-two are active and operational. The video footage is stored for thirty days. Both living units were reviewed by documentation and video footage for five randomly days for ten-minute checks. All dates and dorms had ten-minute checks within the required timeframe, except for one day, in one dorm, where the staff member was observed walking past the rooms without taking the time to look in for safety and security. The assistant facility administrator (AFA) was present during the annual compliance review team's observation of the video footage of ten-minute checks and stated the AFA and facility administrator (FA) would address this incident with the staff member. This incident only occurred once during the shift ten-minute checks. The remaining observations showed staff took the time to walk room-to-room and look into each room for safety and security. The facility administrator explained the timeclock on the video footage is a few minutes off from the clock utilized by the floor staff to complete the ten-minute check observations. This was evident on the youth visual check sheet. Five staff were interviewed, and all staff stated checks are conducted every six minutes when a youth is placed in their room while sleeping or for 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 policy and procedures for census, counts, and tracking. Documentation was reviewed in the logbooks on five randomly selected days which reflected counts were completed every hour and documented in the logbook. The facility operating procedures specifies six specific times when a formal head counts will be conducted during a twenty-four hour time frame; however, those timeframes were not followed, but the facility is exceeding the formal

Department's head count requirement. The logbook also accounts for admissions, transports, and discharges from the program. During the annual compliance review, the power briefly went out, and the floor staff immediately called in an emergency count. Five dates were randomly selected to review formal and informal head counts. Four days reviewed had twenty-seven formal and informal head counts, and the remaining day, had twenty-six formal and informal head counts. The program exceeds the number of required head counts daily as required by the Department. The shift report summarizes a twenty-four hour period and captures events, incidents, and activities. It also shows incoming staff are briefed and review the previous shift report. All required information was clearly documented within the shift report to include incidents, special instructions for supervision, population counts, activities, transport, and admission and releases. For the five randomly reviewed dates, there were no emergency situations, incidents involving mechanical restraints, escapes, or law enforcement requests. There is an admission section, a unit issues section, a transport section, and special instructions section on the logbook document. Perimeter checks are logged in the shift summary notes section. Five staff were interviewed, and four of the five staff stated head counts are completed every thirty minutes. All of the staff stated any discrepancy will result in a recount until the discrepancy is cleared.

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 policy and procedures for logbook entries. The program has bound logbooks with numbered pages. The logbooks are kept and maintained by the shift supervisor. They do not keep separate logbooks in the dormitories; however, program policy states the entire building is considered one living unit. The documentation reviewed in the logbooks for fifteen randomly selected dates found all entries were made in ink with no erasures, had no sign of obliterated or removed verbiage, any errors had a line through it, all entries included the time and name of the staff completing the entry, and the date is listed at the top of each page. The shift report documented a twenty-four hour period and captured events, incidents, and activities. It also captures incoming staff are briefed and review the previous shift report. For all dates reviewed, there were no emergency situations, incidents involving mechanical restraints, escapes, or law enforcement requests. There is an admission section, a unit issues section, a transport section, and special instructions section on the logbook document. Perimeter checks are logged in the shift summary notes section.

Three dates were reviewed in the logbook book containing Central Communications Center (CCC) incidents. In two of the three incidents, the CCC incident was logged in the unit issues and shift summary notes section of the logbook. the remaining CCC incident was logged in the unit issues section, but not in the shift summary notes section of the logbook.

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

The program has a policy and procedures which captures key assignments, inventory and tracking, secure storage, procedures addressing missing and damaged keys. Observations during the annual compliance review found master control staff used the wand on all staff and visitors to conduct a search for contraband upon arrival to the program and when leaving the program. Program staff took every person's keys, provided a key badge with a number, and ensured all individuals signed into the program. All keys were accounted for, based on a review of the inventory sheet and keys within the key storage area. Four staff members' key rings were reviewed during the annual compliance review. All four keys were secured on a locked ring, and all four staff members had the correctly labeled key ring. The permanent issue log for all four key rings matched the number of keys on the key ring and were labelled correctly. The key box is in a locked room which is manned by master control from 6:00 a.m.to 6:00 p.m. The restricted keys were locked in the key box labeled "restricted keys." There were no incidents reported to the Central Communications Center (CCC) regarding key control during the annual compliance review period. The program maintains a key control binder for key inventory, bi-annual inspections, and acknowledgment of permanent keys. Five staff were interviewed about the key control process. All staff interviewed were able to verbalize the key control process to include chits and storing of personal keys, key inventory, youth having no access to keys, and procedures for any missing keys. An informal interview was conducted with the master control technician who stated all individuals who walk into the building are checked with the wand, sign in, and give their keys to the master control operator to be placed in the key box located in master control.

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 policy and procedures addressing contraband procedures. The program has a documented practice to prevent contraband from entering the facility. The facility administrator (FA) was interviewed and was able to provide an explanation of the process of how contraband would be handled and disposed of, following program's policy. A review of the youth handbook and program policy support the documents meets the required items for identifying contraband. The program does not have specific verbiage on bringing currency into the facility for vending machine purposes; however, the program has verbiage in the policy giving the FA discretion to authorize items, and a process in place to keep any currency safe. There are secure lockers in the front office for all of the staff's items. The program policy and procedures cover consequences for contraband, searches of the physical plant, searches of the facility ground, searches of the youth, and searches of incoming and outgoing mail. An informal interview with the program's regional compliance specialist indicated there have been no contraband findings at the program during this annual compliance review period. The policy also addresses disciplinary action for staff found in possession of contraband and contacting law enforcement when illegal contraband is found. The program maintains a room search log. The logbook was reviewed. The logbook contained a weekly schedule for room searches for the entire year. Each of the weekly room searches for the past six months were accounted for in the logbook. The room searches were documented in the logbook and included the date, room number, a section for contraband or unauthorized item, list of items found, reason for confiscation, how the contraband is disposed of, and the staff signature.

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

The program has a policy and procedures regarding searches and full body searches. During the annual compliance review, there were no transports, admissions, off campus activities, or visitation. The annual compliance review team observed classroom transitions on two separate days, all of the youth were searched as required by the Protective Action Response (PAR) training manual, and the required ratio of staff-to-youth was observed. The searches were observed to be a normal practice for the youth and were conducted by a staff member of the same gender. The youth were treated with dignity and respect when being searched. The assistant facility administrator (AFA) was interviewed and reported the youth are searched during every movement at the facility, and this practice was observed during the annual compliance review. Five staff and five youth were interviewed, and all confirmed youth are searched every time there is a movement of youth.

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

The program has a policy and procedures on vehicles and maintenance. The program has one van. The van had its last annual inspection on July 9, 2019. The van had a safety screen separating the front seat and driver's compartment from the rear passenger's compartment. There were no scheduled transports during the annual compliance review. The van was observed to be locked when not in use. The assistant facility administrator (AFA) was informally interviewed and was able to explain the process of a transport which consisted of a staff signing out the van keys and first aid kit from master control. The youth is taken out of the front door, the van is searched, the youth is helped into the van and secured with a seatbelt, and then the doors are closed and locked. The inside door is unable to be opened from the inside. The annual compliance review team was able to observe a fire extinguisher in the vehicle, the appropriate number of seatbelts, and the seatbelt cutter/window punch was attached to the van keys. The AFA reported youth are never attached to the vehicle other than by a seatbelt. A random check of personal vehicles found all vehicles were kept locked when not in use and are located outside of the locked gate.

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 an extensive policy and procedures addressing the transportation of youth. The policy requires a cell phone or radio to be issued to the transporter, the staff ratio of one staff to five youth must be in place for all transports, and at least one of the staff on the transport must be the same gender as the youth. The policy specifically includes high risk and maximum risk youth transportation requirements. The policy also states drivers must have a valid driver's license, staff shall not leave youth unsupervised in the vehicle, and all of the procedures together reflect youth are not permitted to drive vehicles. Observations found the vehicle was locked when not in use and had a safety screen separating the front seat from back seat. During one evening, the annual compliance review team observed one staff vehicle was unlocked. The program was notified and locked the vehicle immediately. All other vehicles checked at the time were secure, and the following morning, all vehicles were found to secure and locked. There were no transports scheduled during annual compliance review. An interview with the assistant facility administrator (AFA) revealed youth always wear a seatbelt during transportation and are never attached to any part of the vehicle. Informal interviews were conducted with master control, AFA, facility administrator, and a randomly selected youth, and all four individuals were able to explain the routine staff-to-youth ratios for transports and consistency of seatbelt usage. Five staff were interviewed to ensure staff are provided with a communication device during transports. All five staff indicated staff are provided a cellular phone for transports.

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 policy and procedures in place explaining who is responsible for conducting weekly security audits, the development and implementation of corrective actions, and an internal system. The program's policy captures the requirements of F.A.C 63E-7.013. Documentation was reviewed which showed during the past six months, a weekly inspection was conducted a minimum of once per week. In an interview, the facility administrator explained the process regarding identification, tracking, deficiencies, and how deficiencies are addressed. There is also a maintenance logbook located in master control where issues are documented for immediate attention. This logbook is checked by maintenance staff on a regular basis and

problems are addressed immediately. The program does not currently have a maintenance staff member and were unable to put estimated timeframes for when current maintenance issues would be addressed because of this. The program is currently using maintenance staff employed by another program located in the same area run by the same provider. Reviewed weekly safety inspections determined weekly safety inspections were completed and updated.

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 policy and procedures addressing the issuance, inventory, and control of equipment and tools. The program's policy and procedures state the program does not keep class A tools on-site. Class A tools are stored off-site at another program. The program maintains an inventory and binder for class B tools. The binder documents all of the tools issued prior to work and after an activity is completed. The shift supervisor exceeds expectations and completes a tool inventory tracking log daily. The policy and procedures mention prohibited tools, missing/lost tool procedures, and how to dispose of dysfunctional tools. Five in-service and five pre-service staff training records were reviewed, and all had documentation to show they received safe tool use training. Five staff were interviewed, and all demonstrated an understanding of which tools are considered class B and can be utilized by youth at the program. All class B tools are secured behind a locked door in the multi-purpose room. Observations found all tools were accounted for daily, were clearly labeled with numbers and images, and were placed in the respective locations.

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 policy and procedures in place for youth handling tools and supervision. The policy has verbiage regarding the supervision requirements of youth using tools. The policy also includes procedures for issuing tools to youth and staff, including risk assessments. The case manager is to bring the risk assessment binder to the daily management meetings and it will be discussed for any updates. Before participation in working with a tool, the risk assessment binder will be reviewed. The ratio established in the policy is one staff to five youth, and a detailed guide for distribution, collection, and search criteria was listed. The policy specifies the program does not utilize disciplinary work projects. An informal interview with the program's regional compliance specialist stated the program does not have vocational training on-site. Documentation for five youth were reviewed for up-to-date risk assessments and all were eligible to utilize class B tools. The assistant facility administrator (AFA) was informally interviewed and reported the five youth whose records were reviewed had utilized class B tools the same morning for clean-up. Five staff were interviewed, and all demonstrated an understanding of which tools are considered class B and can be utilized by youth at the program.

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

The program has a policy and procedures specific to external contractors. The written notification and guidelines for outside contractors include tools to be checked upon arrival and departure, tool restrictions, youth being restricted from work areas, and missing tool follow-up. For two days during the annual compliance review, an outside contractor arrived at program and was observed going through the safety protocol. Master control had the contractor complete the written notification and guidelines document and provided the contractor with instructions. The program also provided documentation to support the outside contractors signed in on the day of the job. Three separate outside contractor invoice dates were reviewed, and all reflected the service dates, invoice dates, and sign-sheet dates all matched. The policy states a maintenance staff member is responsible for the inspection or all tools and equipment prior to it entering the facility.

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

The program has a policy and procedures for the Continuity of Operations Plan (COOP). Documentation supported the program completed fire drills monthly on each shift for the previous six-month period. The program has also completed an emergency drill monthly covering hostage situations, riots, and bomb threats. The documentation included the type of drill, date and time, a brief scenario, and findings or recommendations. All drills documented they went smoothly, and no recommendations or corrective action was necessary. The drill documents identified what page the drill would be notated on in the logbook. Egress plans were found to be located in the main office, the multi-purpose room, and in both dorms. An interview with the facility administrator (FA), reflected COOP drills are conducted monthly and include chemical, severe weather, and riots/disturbances. According to the FA interview, medical and fire drills are conducted monthly on all three shifts Five youth were interviewed and four of the five youth stated they participate in fire drills once a month. One youth stated she participated in fire drills twice a month. Five staff were interviewed about drills; all staff indicated they participate in monthly fire drills. Staff also indicated participating in drills pertaining to weather, bomb threats, medical and mental health, chemical spills, terrorism, escape, major disturbance, flooding, and hostage situations.

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

The program has a policy and procedures for the Continuity of Operations Plan (COOP). The program's annual COOP was reviewed and approved on March 26, 2019 and was signed by all required Department parties. The program's disaster plan is incorporated into the COOP. The COOP is stored in master control and in the facility administrator's (FA) office. Observations during the physical plant tour showed there are multiple signs around the facility stating the COOP is located in the FA's office and in master control. The FA reported all emergency equipment and supplies are kept at the Tampa Residential Facility program location and would be delivered upon a necessary emergency. The program maintains a binder called the Case Management COOP which holds all of the current youths' face sheets and admission cards. The face sheets and admission cards have all the required information needed in the event of an emergency. An interview with the FA indicated a copy of the COOP is located in master control and in the facility administrator's office.

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

The program has a policy and procedures in place for control of hazardous materials. The chemicals are kept behind two locked doors at all times which makes it inaccessible to youth, and a list of approved staff for utilizing the chemicals is attached to the door where the chemicals are stored. The Safety Date Sheets (SDS) matched the current chemicals which are at the facility in the locked storage area, and the inventory sheets matched the number of chemicals observed. The chemical storage, SDS, and inventory contain detergent, cleaners, and laundry dryer sheets.

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 policy and procedures in place for youth handling and supervision for flammable, poisonous, toxic items, and materials. The policy specifically states youth do not use, handle, or clean-up dangerous chemicals. All chemicals are secured behind two locked doors. On the door directly protecting the chemicals is a list of approved staff for handling the chemicals. Five youth were interviewed, and all youth reported they do not use chemicals or cleaning products. The process in place is staff can spray a chemical and a youth can wipe it off. This process is described in both the policy and reflected in the youth interviews. The program also has a policy on preventative and corrective maintenance. Daily preventative inspections are logged in the logbook and a review of the logbook reflected the daily inspections were conducted daily. Weekly inspections are completed by the program administration and documentation reviewed for the past six-month period indicated the inspections occurred weekly. The policy states the program conducts monthly, quarterly, bi-annual, and annual preventative monthly inspections. A copy of the preventative maintenance checklist was provided for the past six months and was found to be complete and accurate. Daily cleaning activities were unable to be observed during the annual compliance review.

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

The program has a policy and procedures in place for the control of hazardous materials. The policy states the physical plant manager is responsible for disposal of hazardous materials. The procedures also indicate the program will dispose of all flammable, toxic, caustic, and poisonous items which can be disposed of on-site, according to Safety Data Sheet (SDS) requirements, and the disposal is to be documented on the applicable disposal form. A review of the physical plant manager's training plan shows they were trained in chemical storage and access, and flammable, poisonous, toxic control. All waste is disposed at the Hillsborough County Waste Management. During the annual compliance review, there was no materials disposed. The program does not keep any hazardous materials at the facility. An interview with facility administrator confirmed the program would dispose of any hazardous materials at the Hillsborough County Waste collection center.

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

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

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

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

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

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

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

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

The program has a policy and procedures for telephone access, visitations, and correspondence. The visitation schedule is posted on the master schedule which is located in the main office, multi-purpose room, and in the dorms. The rules for visitation are posted on the outside gate of the facility. Each youth has an approved correspondence sheet which has been approved by the youth's juvenile probation officer (JPO) and parent/guardian and maintained in the youth's case management record. Visitation is held on Saturdays and Sundays. Reviewed visitation documentation for eight random dates and all visitations had a completed visitation documentation summary, a visitation sign-in/sign-out log, and individual search forms. On one date reviewed, there was no visitation and it was notated on the visitation documentation summary. Youth telephone correspondence is documented in each youth's chronological notes. The phone call rules and telephone schedule are posted on the wall in the case management office. Reviewed five case management records. All five records showed weekly phone calls; however, the times were not listed for length of phone call. One of the five youth records reviewed showed the youth had phone calls every week except when the youth was off-site due to an arrest, and the week she returned to the program. A mailing correspondence binder is kept which has each youth's approved correspondence sheet. The correspondence for each youth is clearly outlined on the log and shows incoming and outgoing mail. Each month, a new log is placed in the youth's section of the binder. Information documented on the log includes the date, number received, number approved, number declined, stamp removed, number to unit, approved correspondence person, and staff initial. Five youth were interviewed, and all indicated they are provided opportunities to correspond when their families. The facility administrator (FA) interview explained alternative visitations are made on an individual basis with the case managers or therapists. The FA also reported cases where they have provided funding for parents/guardians to come to the facility.

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 policy and procedures for controlled observation. The controlled observation rooms meet the requirements of being thirty-five unencumbered square feet, has a metal door with a shatter-resistant window, no vents, a mattress is placed in the room if a youth is staying overnight, the light fixture has a shatter-resistant cover over it, there are no electrical outlets, and the light switches are outside of the room. There was a total of two controlled observations over the past six months. One additional record was requested and reviewed to meet the minimum sample size of three. None of the three controlled observations reviewed were due to a mental health crisis or suicide. One youth was in controlled observation for two hours, one youth was in controlled observation for one hour, and the last youth was in controlled observation for one hour and forty minutes. None of the controlled observations required an extension. All requirements were met for documentation such as staff inspecting the room and the same gender youth searching the youth.

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 policy and procedures regarding controlled observation. There was a total of two controlled observations over the last six months. One additional record was reviewed to meet the minimum sample size of three. None of the three controlled observations reviewed were due to a mental health crisis or suicide. One youth was in controlled observation for two hours, one youth was in controlled observation for one hour, and the last youth was in controlled observation for one hour and forty minutes. None of the controlled observations required an extension and the placement in controlled observation was authorized by a supervisor with delegated authority or higher-level staff. All requirements were met for documentation such as staff inspecting the room, the same gender staff searching the youth, a health care professional of the same gender completing the health status checklist, the youth were advised on the expected behavior for removal, and a supervisor authorized the placement.

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 policy and procedures for controlled observation safety checks and release procedures. Reviewed three controlled observation (two current youth records and one closed record) safety checks and release procedures. All three records reviewed had the first page of the controlled observation report completed and submitted to a supervisor. All three records demonstrated fifteen-minute observations on the observation safety check form. All three records demonstrated written permission from a delegated authority, and the facility administrator approved the release when the threat was no longer imminent. The controlled observations logs were kept in an administrative record and were found in the individual healthcare records for the two current youth. The last youth had been discharged from the program. All three records were reviewed and signed by the FA within the fourteen-day requirement. Due to none of the youth being placed in controlled observation for mental health or suicidal reason, an in-house alert was not warranted.

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

The program has a policy and procedures on safety plans and has established safety plans for all youth, as required by the July 1, 2019 mandate. The safety plans include warning signs, the youth's baseline behaviors, crisis recognition, joint development of coping strategies, intervention strategies preferred by the youth, and debriefing preferences. Five youth records were reviewed, and all youth were admitted prior to the mandate for safety plans; therefore, they were not required to be completed within fourteen days of admission. An additional three records were reviewed for youth who were admitted after July 1, 2019 and all of the records contained safety plans created within fourteen days of admission. There is a section in the safety plan for exposure to trauma as identified during assessments. Due to the mandate going

into effect on July 1, 2019, thirty days has not elapsed for updated safety plans. The safety plans were prepared by the youth, the clinical team, youth care worker, case manager, education, recreation therapist, and facility administrator. The parent/guardian involvement was not documented in this process for the initial safety plans. However, the program has developed a policy and procedures on how they will receive parent/guardian feedback moving forward. The practice at the program is the binders containing all youth safety plans are kept on the floor with the staff at all times.