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): November 3-6, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Marvin D. Bliss, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Brenda Comadore, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Melissa Johnson, Office of Accountability and Program Support, Central Region Supervisor
Courtney King, Youth Environmental Services, Case Manager (Standard 2)
Amanda Nelson, Office of Accountability and Program Support, Regional Monitor (Interviews)
Paul Sheffer, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Jonathan Thompson, Office of Accountability and Program Support, Regional Monitor (Standard 5)

Program Name: Hillsborough Girls Academy
Provider Name: TrueCore Behavioral Solutions
Location: Hillsborough County / Circuit 13
Review Date(s): November 3-6, 2020

MQI Program Code: 1224
Contract Number: R2111
Number of Beds: 20
Lead Reviewer Code: 173

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.07 Residential Assessment for Youth (RAY)	
2.15 Treatment Team Meetings (Formal and Informal Reviews)	
2.20 Exit Portfolio	
3.07 Treatment and Discharge Planning *	

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/Guardian 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)	Limited
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)	Limited
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	Limited
2.21	Exit Conference	Satisfactory
2.22	Safety Planning Process for Youth	Satisfactory

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/Consent	Satisfactory
4.05	Healthcare Admission & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	Designated Health Authority/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Illness/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exposure Control	Satisfactory
4.18	Prenatal Care/Education	Satisfactory
4.19	Licensed Medical Staff*	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	Vehicles and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Management	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 Supervision 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	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

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, Seeking Safety, Action, Values, Victory, and Yes I Can (SAVVY) Sisters, “Don’t Let Your Emotions 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 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 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-seven operational security cameras providing coverage. At the time of the annual compliance review, the program had nine vacant positions; five youth care worker I, two youth care worker II, one shift supervisor, and one master control worker.

Strengths and Innovative Approaches

- Kids and Canines – Therapeutic dog program - Kids and Canines offer a social skill building and therapeutic dog training program. Our program services target children who need to improve both behaviorally and socially. The youth are selected by therapists, counselors or teachers who have contacted us because they believe we can help these children with our non-traditional services.
- General Education Diplomas (GED) and American College Testing (ACT)–) Graduation ceremonies for the graduates.
- College classes offered.
- Brain Bowl – Team Academic Challenge - Brain Bowl participation across the state is a supplemental activity which is being rolled out by the Department of Juvenile Justice (DJJ) Education Team. This academic activity will not only test the youth's knowledge of topics within the four major subject areas, but it also will result in a team of youth becoming the DJJ 2020 Brain Bowl State Champion.
- Work out challenge incentive. Youth challenge themselves to various workouts for better health and fitness
- Quarantine Projects - To put a smile on the faces of cancer patients who are quarantined. The youth made cards and made masks to deliver to BayCare Infusion Center. The youth were very excited about this project and really did a great job. The items will be placed in a gift bag for the patients.
- Provides items for crafts and card making activities for holidays, birthdays, etc.
- Special activities during a grief/loss anniversary.
- Florida Youth Justice Council Youth Advocacy (FYJC)- The FYJC is a partnership established to promote continuous juvenile justice system improvement. The commission provides support to local sites and works to implement reform which could impact the entire state. FYJC's Youth Advocacy Council (YAC) work in partnership with the FYJC to ensure the voices of system-impacted young people are considered in juvenile justice reform efforts statewide.
- Unsung Portrait competition. Youth created portraits of unsung heroes and displayed them in the lobby for visitors to see.

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 policy and procedures addressing pre-employment background screenings. Seven applicable staff records, one contracted provider staff and two volunteer records were reviewed for background screenings. All ten records reflected an eligible background screening from the Agency for Healthcare Administration (AHCA) Clearinghouse through the Department's Background Screening Unit (BSU). For each of the ten records reviewed, background screenings were completed prior to the date of hire, criminal histories were reviewed, and a pre-employment assessment tool was administered to direct-care applicants. Each of the seven direct-care staff received a passing score on the pre-employment assessment tool. The program's Annual Affidavit of Compliance with Level 2 Screening Standards was completed for the program and sent to the BSU on December 10, 2019. The Annual Affidavit of Compliance with Level 2 Screening Standards for education staff was completed and sent on December 6, 2019.

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 policy and procedures ensuring staff receive a background rescreening every five years from the initial date of employment. One staff at the program required a background rescreening during the annual compliance review period. The staff received a rescreening within twelve months of their five-year anniversary of the initial agency hire date.

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 has a policy and procedures to ensure program-related incidents, which place at risk, or have the potential to place at risk, the health, safety, or welfare of the public or of youth, staff, or visitors, the security of the facility, or the reputation of the provider are reported and handled appropriately and in a timely fashion. According to the written policy and procedures, abuse reporting procedures are as follows: any staff who have knowledge of, or has a reasonable suspicion a youth has been, is being, or is in danger of being abused, should immediately report it to the Florida Abuse Hotline (for youth under the age of eighteen), or the Central Communications Center (CCC) Hotline (for youth eighteen years of age or older). If a youth is requesting to contact the Florida Abuse Hotline, policy states staff are to notify the staff mentor (supervisor), who will assist the youth in making the call. The program has had no substantiated instance of physical, psychological, or emotional abuse since the last annual compliance review.

The program had two substantiated incidents with a finding of improper conduct and one substantiated code of conduct. Staff adhere to a code of conduct, as indicated in the receipt of the employee handbook contained in the staff record. All five reviewed pre-service records reflected staff received training on child abuse reporting. The Florida Abuse Hotline and CCC numbers were observed posted throughout the facility. All five interviewed youth reported they feel safe in the program. All five youth reported they have never been prevented from making a call to the Florida Abuse Hotline. All five youth reported staff are respectful when talking with youth. Each of the five staff interviewed were familiar with the program's abuse reporting procedures. Staff reported they have never observed a co-worker denying a youth the right to an abuse call, and all five reported they have not witnessed their co-workers using profanity or threatening behavior when dealing with a youth. The facility administrator reported youth and staff are given instruction on abuse reporting at respective orientations, and annually thereafter for staff.

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

The program had thirty-three high-risk and three maximum-risk reported incidents, five allegations of abuse were reviewed, meeting the ten percent requirement of the indicator, of which one was found substantiated. In all five instances, program administration took immediate action by removing the staff from contact with youth. Four reported incidents were found to be unsubstantiated. In the one incident found to be substantiated, the staff was terminated for improper conduct and violation of the employee code of conduct.

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 policy and procedures to ensure program-related occurrences which place at risk, or have the potential to place at risk, the health, safety, or welfare of the public or of youth, staff or visitors, the security of the facility, or the reputation of the program are reported and handled appropriately and in a timely fashion. The program had seventeen incidents reported to the Central Communications Center (CCC) during the previous six months. A sample of five incidents were reviewed. All five incidents were reported within two hours. Documentation in the facility logbooks was found for all five CCC reports. The program has experienced an increase in the number of reportable incidents to the CCC since the last annual compliance review. According to the facility administrator, incidents which are determined reportable are called into the CCC within two hours and documented in the program's logbook. She reported significant incidents impacting operational safety and security are reported internally, and for qualifying incidents, to the CCC. The program has a practice of calling the CCC if they need clarification regarding whether an incident is reportable. A comparison of reportable incidents during the same time period last year showed an increase of the reportable incidents from five incidents during the same time period last year, to seventeen incidents this year. Nineteen of the thirty-six incident reports were COVID-19 related, leaving seventeen total incidents reported for the twelve month period.

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 had six incidents of utilizing Protective Action Response (PAR) techniques during the previous six months. Five PAR reports were reviewed. All five reports were completed by the end of the staff member's shift and included statements from all staff involved. Mechanical restraints were not utilized in any of the PAR incidents. None of the reports resulted in an

allegation of abuse. All five reports reflected a review by a PAR certified instructor/supervisory staff and post-PAR interviews were completed with the youth involved within thirty minutes of the incident. All five reports were reviewed by the administrator or designee within seventy-two hours of the incident. None of five reports indicated the need for a PAR medical review; however; medical reviews were conducted by the on-site medical staff for all five PAR incidents. The program submitted all PAR incidents to the Department by the fifteenth of every month during the annual compliance review period. The program's PAR plan for the 2020 year was approved by the Department in January 2020. The program's PAR rate during the annual compliance review period was 0, which is below the statewide Residential PAR rate of 2.35. According to the facility administrator, all PAR reports are reviewed and compared to video surveillance of the incident. The facility administrator added, the program follows up appropriately if use of PAR is unwarranted or improper.

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 policy and procedures ensuring all newly hired staff are sufficiently prepared to meet the needs of the program and youth in their care. According to the program's policy and procedures, staff must complete a minimum of 120 hours required training within the first 180 days of their hire date. Training documentation was available for review within the Department's Learning Management System (SkillPro). All five reviewed pre-service training records indicated all the staff had in excess the required 120 hours. Each of the five staff members completed the required training prior to having any contact with youth to include: cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), ethics, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA).

Contractual-required training was completed and includes the following: stress management, gender responsive services for adolescent youth, positive reinforcement techniques and strategies, emotional and behavioral development of children/adolescents, risk factors for delinquency and their treatment, physical development, restorative justice, risk factors and triggers relating to youth with a history of victimization, universal precautions and emergency evacuation procedures, human trafficking, PREA, program's treatment model and immediate access to emergency medical, mental health, and substance abuse services. All instructors are qualified to deliver training provided to staff. All pre-service training was observed to be documented in SkillPro. The program submitted, in writing, a list of pre-service training to the Department's Office of Staff Development and Training, which was approved on February 19, 2020. The program has an annual training in-service calendar, which is updated as changes occur.

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 has a policy and procedures ensuring all staff maintain the necessary training to meet the needs of the program and youth in their care. All five reviewed in-service staff completed the required mandatory in-service courses to include: cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR) update, ethics, and suicide prevention. All five in-service training records reflected each staff completed over twenty-four hours of annual training. The program had three applicable supervisory staff at the time of the annual compliance review. Two of the five staff had more than the required eight hours of supervisory training in the areas of management, leadership, personal accountability, employee relations, and communication skills. None of the staff reviewed were eligible for fiscal training. The program employs one registered nurse (RN), who had current certifications for CPR with AED. All training was observed to be documented in the Department's Learning Management System (SkillPro.) The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training and the training plan was signed on February 19, 2020. The program has an annual training in-service calendar, which is updated as changes occur.

1.09 Grievance Process	Satisfactory Compliance
Program staff shall be trained on the program's youth grievance process and procedures. The program adheres to their grievance process and shall ensure it is explained to youth during orientation and grievance forms are available throughout the facility. *Completed grievances shall be maintained by the program for a minimum of twelve months.*	

The program has a policy and procedures for youth to formally file complaints about conditions, treatment, services, and the actions of program staff and other youth in violation of the youth's rights and to ensure such complaints are reviewed in a fair and timely manner, resolved to the best interest of the youth, the program, and the Department. The program's grievance process includes an informal phase, including verbal dialogue and "Chatty Cathy" forms, a written or formal, and appeal phase, in which youth utilize the grievance form. According to the policy and procedures, the program has seventy-two hours to handle informal and formal grievances. The program reviews all grievances during morning management meetings and are followed-up on within twenty-four hours.

The program had twenty-one grievances filed within the previous twelve months since the last annual compliance review. Three grievances reviewed were related to youth complaints against staff, one was a medical complaint and the last one was for discipline. Five grievances were reviewed, and all were responded to and/or resolved the same day the grievance was submitted or within twenty-four hours. Each grievance was reviewed by the facility administrator within seventy-two hours. The program maintains copies of grievances for twelve months. Grievance forms were observed available to youth on the dorms and the grievance book carried by staff, as well as a locked grievance box. A review of five pre-service records reflected all staff

completed training on the program's grievance procedures. Each of the five youth interviewed were familiar with the program's grievance procedures. All youth reported they can ask for assistance in filling out grievances and forms are available to them by asking staff. All five staff interviewed were familiar with the program's grievance forms location and the procedures. According to the facility administrator, youth can informally handle a grievance verbally or through "Chatty Cathy" forms.

1.10 Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement interventions for each youth. Interventions shall include, but are not limited to, evidence-based practices, promising practices, or practices with demonstrated effectiveness. Staff whose regularly assigned job duties include the implementation of a specific intervention and/or curriculum must receive training in its effective implementation.	

The program provides Voices; A Program for Self-discovery and Empowerment for Girls, which is a gender responsive group. The Voice's group is bundled with The Teen Relationships Workbook group. This curriculum encourages youth to explore, identify, and evaluate their relationship histories in order to promote insight into patterns of healthy and unhealthy relationships. Thinking for a Change (T4C) and Impact of Crime (IOC) are delinquency intervention groups. The groups are designed to promote insight and understanding into how thought patterns and conduct impact themselves and their community. At Hillsborough Girls Academy, at a minimum each youth will complete at least one delinquency group prior to release. All youth are enrolled in both groups during their stay. These groups are classified by the Department as evidence-based or a promising practice and provided as contractually required.

The program has two master's-level therapists with experience working with juvenile offenders. Education and work experience are considered by the administration when determining staff delivery of delinquency intervention services. All staff facilitating specialized services groups have received the required training.

Group sign-in sheets were available for review and found groups were delivered, as designed. A review a five youth records found all have participated in either T4C or IOC. All the youth reviewed are currently participating in a VOICES and Teen Relationships. The performance plans for each of the five youth addressed a prioritized need. The program's activity schedule reflects the program is providing structured, and planned programming or activities at least sixty percent of the youth's awake hours. According to the facility administrator, all facilitators are trained to facilitate the specialized service groups.

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 policy and procedures in place regarding life skills training provided to the youth. The program provides a wide variety of interventions focusing on the development of life and social skills in youth. The clinical staff facilitate the following curricula to foster life skills growth for the youth: VOICES: A Program of Self-Discovery and Empowerment for Girls, Thinking, Feeling, and Behaving, Dialectical Behavioral Therapy (DBT) Skills Training, Conflict

Resolution, Teen Relationships, Safety, Action, Values, Victory, and Yes I Can (SAVVY) Sisters, and Social Success.

A review of five staff training records found all group facilitators were trained to deliver their respective curricula, with all facilitator's having at least a master's-level education. The groups address skills streaming, communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, substance abuse, critical thinking, and problem solving. A review of group sign-in sheets confirmed the clinical mental health overlay services groups are held seven days a week, as required. Interviews with five youth confirmed attendance in groups such as VOICES, anger management, social skills, teen relationships, and emotional recognition. The youth stated they learned new skills on how to deal with anger, coping skills, different ways to express feelings, and strategies for relapse prevention. They indicated they role play during group activities to work on the new skills learned, and each share personal strategies used to put their new skills to use. An interview with the clinical director confirmed the therapists follow the group schedule, and indicated he conducts weekly fidelity checks on the provided groups. A review of five youth case management and mental health records confirmed each youth received services, as outlined in their individual performance and treatment plans.

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.	

A review of the program's contract reflected the program provides Thinking for A Change (T4C) and Impact of Crime (IOC) to youth in the program. Each group is provided twice a week in the evenings. A review of the program's activity schedule reflected T4C and IOC are conducted twice a week. Youth also participate in community service projects which helps to increase awareness and empathy for crime victims and survivors. Youth have participated in car washes to raise money for victim funds and local community charities. An informal interview was conducted with the recreation therapist who facilitates the IOC group and she stated guest speakers are brought in to speak to the youth about their experiences of victimization and the youth watch video victim speakers over the course of the group. The youth at Hillsborough Girls Academy cannot participate in off-site activities. Each of the five reviewed youth records reflected all youth are currently participating in IOC or T4C. Group sign-in sheets were available for review and found groups are delivered, as designed. All five youth interviewed were able to report the current groups they are participating in and new skills or behaviors they have learned.

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

A review of the program's contractual agreement found the program is providing Voices; A Program for Self-discovery and Empowerment for Girls, as a gender-responsive group. The Voices group is bundled with The Teen Relationships Workbook group. This curriculum encourages youth to explore, identify, and evaluate their relationship histories in order to promote insight into patterns of healthy and unhealthy relationships. The program also utilizes the Safety, Action, Values, Victory, and Yes I Can (SAVVY) Sisters, and Mean Girls groups

which focuses on needs specific to the female population served by the program. The program provides Healthy Body and Brain Matters which is focused on gender-specific health issues.

A review of the curriculum, group materials, and youth sign-in sheets confirmed the program provided the services, as required. The program designed services based on the common characteristics of the female population, to include youth ages and service needs. A review of the program's activity schedule found provisions for gender-specific programming. Youth interviews found all five youth stated they have participated in the following groups: Voices, Teen relationships, Impact of Crime, Thinking for a Change, and Reaching Out. All five youth were able to explain the new skills they learned and have practiced while in the program. The facility administrator was interviewed concerning gender-specific programming and stated treatment planning is based on the individualized needs of the youth and gender responsive programming is offered which creates a therapeutic environment.

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 policy and procedures which addresses and determines how youth alerts are identified, documented, updated, and communicated to program staff. Five youth records were reviewed to address the program's entering alerts in the Department's Juvenile Justice Information System (JJIS). All five youth records reflected alerts were entered into JJIS, as required. All alerts were verified prior to their entering into JJIS. Each of the five youth alerts reviewed were applicable for, and found evidence of, being documented within the program's logbook and shift reports. A review of the program's internal alerts found they were consistent with alerts entered within JJIS. All alerts requiring removal or downgrading were found to have been done so by the appropriate staff member.

The facility administrator was interviewed concerning the program's internal alert process, as well as the process of entering alert information into JJIS. The facility administrator stated alerts are entered in JJIS by case management (security), clinical staff (mental health and substance abuse), and medical staff (medical and food allergies), respectively. Those alerts are reviewed daily during management meetings and posted in the staff master control office for review by all incoming staff. She reported dietary alerts are posted in the kitchen. Five interviewed staff reported they are briefed on youth alerts through briefings with shift supervisors, and the internal alert board located the administration office.

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

The program separates the youth records into three separate records: an individual management record, individual healthcare record, and mental health and substance abuse record. All youth records are marked 'Confidential.' All records are maintained in locked cabinets within the responsible program area's office. No records were observed to be accessible to youth. Office area doors are also marked 'confidential.' A review of five individual management records found each record had a label which included the youth's name, Department identification number, date of birth, county of residence, and committing offense. Each record was divided into the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous.

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

The program has formal processes to promote input from youth. A review of sign-in sheets and agendas found evidence the program hosts daily meetings, community meetings, and monthly Youth Advisory Board meetings. The program provides "Chatty Cathy" forms for youth to submit ideas, needs, or concerns. The forms are available in various program areas. Youth may complete the forms and submit them to staff in order to speak with designated staff and administration concerning issues they may have. In addition, the program conducts regular surveys for youth and parents/guardians. The facility administrator was interviewed concerning the program's efforts to provide youth the opportunity to give input, which revealed this is done through the use of daily meetings and the Youth Advisory Board. Five youth were interviewed concerning their ability to provide input into programming operations. All five youth reported they are able to provide input about what happens at the program. The youth reported they can do this through the Youth Advisory Board, "Chatty Cathy" forms, grievances, daily meeting and community meetings, and informal discussions with administrators.

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

The program has a policy and procedures for maintaining an advisory board. Reviewed documentation reflected the program participated in quarterly board meetings with two other programs located on the same campus (Lake Academy and Tampa Residential Facility). This practice of holding meetings together was approved by the Assistant Secretary of Residential Services on March 8, 2017. A review of documentation reflected the meetings were held on November 14, 2019, February 13, 2020, May 14, 2020 and, August 27, 2020. Reviewed documentation reflected consistent attendance by members of the business community, school board, and members of the faith community. The program was able to present documentation

reflecting emails and other correspondence to solicit active involvement of other interested community partners. These included law enforcement representatives, local judges, a member of the lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) community, a victim advocate, and the parent/guardian of a child previously involved in the juvenile justice system. The reviewed meeting minutes reflected specific information being shared for each of the three programs involved. An interview with the facility administrator revealed they have reached out multiple times to interested parties and were able to show follow-up with them as well. Unfortunately, the invitees were unable to attend for various reasons. An interview was unable to be conducted with a board member by the review team.

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

The program provides youth and parents/guardians surveys to complete in order to utilize data for program planning. Surveys include admission surveys, discharge surveys, and quarterly surveys sent out during the youths stay. The survey results are incorporated into the planning process through sharing of information in monthly all-staff meetings. This information was verified through a review of meeting minutes and agendas. The facility administrator uses meetings as a system of communication to keep staff informed and allow them opportunities to provide input and feedback pertaining to program operations. The program has a staff retention plan, which includes steps to minimize turnover and improve staff morale. These include recognition rewards, incentive rewards, employee referrals, and bonuses. The program has a policy and procedures for staff communication to include opportunities for providing input and feedback on the program's operations. The program communicates important information by shift briefings and daily management meetings.

All five interviewed staff reported staff meetings were held monthly. The five interviewed staff reported topics of meetings included important and valuable information such as issues with youth, daily activities, changes in policy and procedures, trends, updates, new staff introductions, and drills. Four of the five staff reported they were briefed on surveys results and annual reports. Three of five staff reported the communication at the program was very good and two staff reported communication was good. The facility administrator (FA) reported a high turnover year for the program and morale is challenging because of vacancies and the COVID-19 pandemic. The FA also reported she is addressing this by employee recognition, appreciation, and interviewing potential new staff. The FA was questioned regarding outcome data used by the facility, and how the information was used for program planning. The FA stated they review the Comprehensive Accountability Report (CAR) and Monitoring and Quality Improvement (MQI) results, as well as surveys in all staff meetings and work to improve services based on feedback.

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

The program has a policy and procedures for evaluating staff, performance standards, and the frequency of evaluations. The program's policy indicates evaluations are to be completed annually, or as deemed appropriate by the supervisor. A review of a sample position description was conducted and determined each staff member's performance standards were clearly identified. A sample of performance evaluations were reviewed and determined to be completed

consistently with the program's policy. Staff are evaluated at least annually on their established performance standards. The performance standards matched job descriptions for each staff position reviewed. A review of the program's contractual agreement found all key positions were filled at the time of the annual compliance review. The facility administrator was interviewed and stated supervisors rate staff based on key performance indicators and set goals for each staff to attain beyond these. Five staff were interviewed and asked how often they receive performance evaluations. Three staff reported annually, and two staff reported every six months.

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

The program provides a variety of recreational and leisure activities to include basic physical fitness, team and individual sports, art, leadership, and teambuilding activities. The program has a posted activity schedule. The program has a policy and procedures which provides activities based on the developmental levels and needs of the youth in the program. Activities include a choice of leisure and recreation options. Youth are encouraged by staff and activity options to explore interests. Youth were observed to be engaged in constructive use of leisure time. Activities promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program takes precautionary measures to prevent over-exertion, heat stress, dehydration, frostbite, hypothermia, and exacerbation of existing illness or physical injury, some of which is documented in the logbook (outside temperatures and conditions, physical plant issues).

The program's contract includes one recreational therapist position. A review of the program's staffing roster, as well as the therapist's credentials, schedule, and services provided to youth demonstrate all requirements were met. A review five youth records demonstrated the therapeutic activities provided are part of each youth's performance and/or treatment plan. The program has a formal process to promote constructive input by youth. Five youth were interviewed. Each of the youth agreed there are physical activities and leisure activities provided for at least one hour a day. Youth described some of the activities to include flag football, basketball, volleyball, television, listening to the radio, dodgeball, kickball, watching movies, and character building games with treatment staff. Each of the five-youth affirmed they are provided with varying degree of mental and physical exertion throughout the day. Five staff were interviewed, and each were able to provide an example of what types of indoor and outdoor activities are provided to the youth.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedure ensuring each youth's parent/guardian is contacted by telephone within twenty-four hours, and in writing within forty-eight hours, of the youth's admission to the program. The program is required to notify the youth's committing court, assigned juvenile probation officer (JPO), and post-residential counselor, if applicable, within five working days of the youth's admission. A review of five youth case management records found each youth's parent/guardian was contacted by telephone within twenty-four hours of admission and each record contained documentation confirming the youth's parent/guardian was notified in writing, within forty-eight hours of admission. All five records had documentation indicating the JPO, post-residential counselor, if applicable, and court were notified of the youth's admission the same day the youth was admitted to the program.

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 policy and procedures to ensure on the day of a youth's admission, the youth will be oriented on the program's rules, procedures, schedule, and services. The program provides a youth handbook detailing all the required elements. A youth's parent/guardian is mailed a parent handbook covering all required elements. Five youth case management records were reviewed. Four the five records contained an orientation checklist acknowledgement form signed by each youth confirming completion of an orientation. One youth record was missing the orientation checklist acknowledgement form, however, all other orientation forms completed upon admission were present, indicating orientation took place. 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 policy and procedures to obtain written consent of any youth eighteen years of age or older, to address approval for release of their confidential information to a parent/guardian. Five youth case management records were reviewed and two were applicable for written consent. The program provided one additional youth case management record of a youth meeting the requirements of the written consent criteria. All three reviewed applicable

records included an updated signed consent form, which was completed by each youth prior to their eighteenth 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 policy and procedures on the utilization of a classification system which promotes the safety and security, as well as the effective delivery of treatment services. The initial classification of youth is used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, youth group, or staff advisor. A review of five youth case management records found each youth's initial classification was completed on the day of their admission to the program. The initial Classification forms contained all required elements. Each Classification form included a review of each youth's possible risks including suicide, mental health, medical, and escape risks. The program's policy and procedures require the youth to be screened for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) prior to receiving a room assignment. All five records documented a VSAB form was completed in the Department's Juvenile Justice Information System (JJIS) prior to assigning the youth to a room.

Five youth case management records were reviewed. All records contained the standard Classification form with required elements completed in its entirety. Five applicable records revealed documentation of identified or suspected risk factors, which all alerts were entered into JJIS and program internal alert system. 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. An interview with the facility administrator indicated upon admission to the program several screening documents are completed to help determine room placement and unit placement for the youth. Gang affiliations, criminal history, identified special needs and history of violence are all taken into consideration when determining unit and room placement.

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 policy and procedures in place addressing gang identification and notification to the school district and law enforcement. Five youth case management records were reviewed and two were applicable for suspected gang activity. The program provided one additional youth case management record of a youth with suspected gang activity. All three applicable youth records for identification and notification of gang activity found local law

enforcement, and the youth's home county law enforcement were notified of each youth's suspected gang activity. The youth's educational providers, juvenile probation officers, and post-residential counselors (if applicable), were all notified of the suspected gang activity. Each of the youth had gang alerts entered into the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures to ensure youth identified as gang related are provided gang prevention and intervention activities. Five youth case management records were reviewed and two were applicable for suspected gang activity. The program provided one additional youth case management record of a youth with suspected gang activity. All three records reviewed incorporated a gang goal in the youth's individual performance plan addressing the need for gang awareness and intervention services. 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.

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

The program has a policy and procedures ensuring each youth receives an initial assessment within thirty days of admission. The program is to maintain all documentation of the initial assessment in the Department's Juvenile Justice Information System (JJIS). A review of five youth case management records found each youth had a Residential Assessment for Youth (RAY) completed in JJIS within thirty days of admission. The program's policy requires each youth to receive a RAY Reassessment within ninety days of the initial assessment, or when deemed necessary by the intervention and multidisciplinary treatment team. Four of the five reviewed records contained RAY Reassessments which were completed late. Seven total RAY reassessments were required, two were completed within the ninety-day requirement. Documentation indicated five RAY Reassessments were completed late by three, twelve, fourteen, forty-three, and sixty-seven days. One of the records reviewed did not qualify for a RAY Reassessment, as the youth was still in the ninety-day window of the initial assessment. All RAY Reassessments were maintained in the youth's 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 policy and procedure ensuring a Youth Needs Assessment Summary (YNAS) is completed within thirty days of each youth's admission to the program. A review of five youth case management records determined each youth had an YNAS completed within thirty days of admission. Each YNAS was documented in the Department's Juvenile Justice Information System (JJIS), as required.

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 regarding the development of performance plans, goals, and transmittal. All five reviewed case management records found the youths' performance plans were developed within thirty days of the youths' admission to the program. All five performance plans were developed after the initial assessments were completed. Four of five plans were signed by the youth, intervention and treatment team leader, and all parties who have significant responsibilities in goal completion. One record was missing a youth signature as well as the mental health provider signature. All records reviewed had documentation indicating the plans were mailed to the parents/guardians. All five performance plans contained the youth individualized goals and were based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process. Each of the plans addressed the youth's top three criminogenic needs and specific delinquency interventions with measurable outcomes. Each of the plans identified program staff and youth responsibilities in accomplishing each of the goals, as well as target completion dates. All records contained documentation indicating copies of the plans were sent to the youth's committing court, juvenile probation officer (JPO), and parent/guardian within ten days of completion. Interviews with five youth indicated each of the youth participated in the development of their performance plan and has a copy of the plan.

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

The program has a policy and procedures regarding performance plan revisions. Performance plan revisions are completed when deemed necessary by the intervention and multidisciplinary treatment team. One of the five records indicated a need for a performance plan revision due to the Residential Assessment for Youth (RAY) Reassessment results, however it was not completed. Three of the five records had documentation of the multi-disciplinary team addressing performance plan revisions. None of the plans required revisions due to newly acquired information.

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 on the completion of performance and release summaries. Four of the five had performance summaries completed every ninety days as required. One youth was still within the ninety-day window of admission and did not require a performance summary. The completed summaries contained the status of each youth's performance plan goal, the overall treatment progress, the youth's academic progress, behavior, readiness to change, interactions with peers and staff, behavior adjustment to the program, positive and negative events, and if applicable, justification for release. The youth are allowed to read and add comments prior to signing the summary and are provided a copy of the completed summary. The original performance summary was maintained in the youth's case management record and contained all required signatures.

A review of three closed youth case management records found all release summaries were completed, as required. Each of the three records had documentation indicating the parent/guardian was provided written notification of the youth's planned release once approved by the court. Two of the three closed records did not contain documentation of the information being sent to the required parties. All three youth records contained a discharge summery completed and distributed within the ten day requirement and all three had the required signatures. All three records included a Residential Assessment for Youth (RAY) exit assessment. All five interviewed youth reported they were provided a copy of the performance summary which was sent to the court.

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

The program has a 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. The program encourages each youth's parent/guardian to participate in the youth's case management and treatment services. Upon admission, each youth's parent/guardian is mailed a letter which includes a brochure and handbook which describes the services offered to the youth at the program. Included in the letter are the dates and times of the youth's treatment team meetings. Parent/guardians are encouraged to participate in person; however, if this cannot be arranged, parent/guardians may participate by telephone. Each of the five records contained documentation indicating the youth's parent/guardian was involved in the youth's assessment process, participated in the development of the youth's performance plan, received progress reviews, and participated in formal treatment team meetings, when available.

During the annual compliance review, two formal treatment team meetings were observed. The case manager made contact with each youth's parent/guardian and juvenile probation officer. An interview with the facility administrator revealed parent(s)/guardian(s) are mailed multiple treatment team meeting feedback forms to provide their input on what they believe their youth can work on while at the program. Parent(s)/guardian(s) are contacted by telephone monthly for treatment team meetings to express any questions or concerns they may have about the youth's treatment plan and behavior in the program. Each of the five interviewed youth reported their parent(s)/guardian(s) participate in treatment team meetings by telephone every month.

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 policy and procedures regarding members of the treatment team. According to the program's policy and Department Rule, the treatment team is to be comprised of the youth, representatives from the program's administration, residential living unit, education staff, and others directly responsible for providing or overseeing the provision of intervention and treatment services to the youth. A review of five youth case management records found treatment team members included the youth, treatment team leader, a representative from administration, a youth care worker, education, recreational therapist, the youth's juvenile probation officer by telephone and a parent/guardian by telephone.

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 policy and procedures to address incorporation of other agencies into each youth's treatment and performance plan. Five youth case management records were reviewed for incorporation of other plans into the youth's performance plan. Each of the youth's performance plans incorporated additional plans including the youth's academic, mental health,

and wellness plans. None of the youth required a Department of Children and Families care plan.

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Limited 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 ensuring formal treatment team meetings are held for each youth every thirty days. A review of five youth case management records found formal treatment team meetings were not held every thirty days for each youth and informal meetings were not held bi-weekly, as required. Documentation for each of the formal and informal treatment team review meetings included the youth's name, date of review, comments from treatment team members, a brief synopsis of the youth's progress, performance plan revisions, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, and Residential Assessment for Youth (RAY) Reassessment results.

A review of individual treatment team documentation found the first youth to have thirteen formal and seven informal treatment team meetings of the thirteen required. The second youth had six formal treatment teams and zero informal treatment teams documented of the six required. The third youth had six formal treatment teams and two informal treatment teams documented of the six required. The fourth youth had three formal treatment team of the four required and four informal treatment teams documented. The fifth youth had one informal treatment team and was not due to have an initial formal treatment team due to being in the thirty day completion of the performance plan window.

Observations of two youth treatment team meetings found all required parties were in attendance except for education. Written feedback from the education representative was provided and read aloud by the case manager for one of the youth. The case manager contacted both youth's parents/guardians. Additionally, all topics were discussed, as required, except for the safety plan. All members of the treatment team were actively involved in the meetings and the youth were provided opportunities to demonstrate skills acquired at the program. All five youth interviewed, reported staff reviews their performance to include progress on performance plan goals, positive and negative behaviors, and treatment progress. All five youth reported receiving the opportunity to review their performance plan, goals and, positive and negative behaviors as well as demonstrate any skills learned while at the program during treatment team meetings.

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

The program has policy and procedures in place addressing career education. The education program has in place policies and procedures which address' and ensures the instruction of a career education curriculum. This program of study, which is conducted and supervised by the School District of Hillsborough County, is identified as a Type Three Career Educational Program. The course programming includes but not limited to; instruction of interpersonal communication skills, personal accountability skills and behaviors leading to appropriate work

habits for positive post-release employment and living standards. The curriculum, which is age appropriate for the students it targets, is suitable to their learning and ability skills as well as to their length of stay within the program. The content of this programming provided not only an orientation to the broad scope of career choices based upon personal abilities, aptitudes and interests but likewise, the content and/or prerequisites needed for entry into a specific occupation. The youths participating in this course offering were introduced to and completed employment résumés and sample employment applications which were included in the youth's exit portfolios.

Three closed files were reviewed, and each contained résumés and employment applications. Each file contained the following: a post-release calendar (Plan for Success) which identifies the location of and contact information of a career source office either in or near the community in which they will be residing upon exit from the program, as well as appropriate documentation to gain employment (a valid state identification card or license, a birth certificate and social security card). Due to the on-going pandemic and its restrictions, one record was missing a valid state identification card. This was due to the closure of the Department of Motor vehicles office located near the program. Additionally, each record contained evidence identifying the youth's parent/guardian, juvenile probation officer as well as the youth's program case manager were aware of the vocational plans and the post-release discharge plans of the youth. The facility administrator confirmed the program provides Type 2 education programming to include employment applications, résumé, state issued identification, Career Source appointments, and preparation for the General Equivalency Diploma (GED) if a youth is eligible. The lead teacher indicated Florida Ready to Work is utilized and the youth receive state certifications through this curriculum.

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 policy and procedures in place addressing educational access. The facility's educational component is directly managed and supervised by the Hillsborough County School District. Reviewed documentation as well as input from the program's lead instructor indicated each youth in the program was provided a minimum of 250 days instruction during the calendar year and each calendar week contained a minimum of twenty-five hours of classroom teaching. To provide teacher preparation/planning, ten days were incorporated into the calendar year. A review of the program's daily academic schedule indicated the school day started at 7:45 a.m. and concluded at 2:05 p.m. Access to the program's logbook entries and video system verified the classes were being conducted with minimal interruptions. All five youth interviewed found the classes were being conducted on time and without interruptions. An informal interview with the lead teacher indicated they have implemented an educational schedule which meets the 250-day requirement for the educational calendar year, with a minimum of twenty-five hours of educational time weekly. Five youth interviews indicated they attend class according to the posted schedule and have no interruptions.

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

The program has policy and procedures in place addressing transition planning. Upon the examination of three closed youth records, it was evidenced each youth had in place a program developed Education Transition Plan. This plan which was developed upon the youth's admission into the program, was modified if needed, while in residence and centered on the youth's post-release educational goals. A review of the three closed records indicated the plans were developed with the input from youth, as well as from the program's education and aftercare staff and was based solely upon the youth's individual assessed needs, performance as well as post release goals whether they be a continuation of their education or employment. Furthermore, each plan spoke of key monitoring responsibilities and were acknowledged by individuals who are responsible for the re-integration and coordination of the provision of support services for the youth upon release from the program. Through signed acknowledgment, it was verified the youth, the parent or guardian, department and instructional personnel from the residential program, and personnel from the school district of which the youth would be returning to following release were directly related to the plan's creation and implementation. This included either a certified school counselor or others from the school district who are responsible for providing academic guidance services. Four of four applicable youth surveys indicated youth are involved in the development of their educational transition plan. One youth surveyed was not applicable.

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 policy and procedures addressing transition planning, conferences, and Community Re-Entry Team (CRT) meetings. A review of three closed youth case management records found each youth had a transition conference held at least sixty days prior to their targeted release date. Each record documented the youth's juvenile probation officer (JPO), parent/guardian, education staff, and any other additional pertinent parties were invited and encouraged to participate in the youth's transition conference. All three records documented a CRT meeting was conducted prior to the youth's release. Each of the records contained an email invite, inviting the case manager and youth to participate in the meeting. Documentation in each of the records indicated the youth and case manager participated in the CRT meeting; however, there was no documentation indicating the transition manager participated.

2.20 Exit Portfolio	Limited 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 released back in the community. Three closed youth case management records were reviewed for exit portfolios. None of the records had documentation indicating the exit portfolios were discussed or initiated at the transition conferences. All three exit portfolios contained a copy of the youth's transition plan, educational records/documents, school transcripts, résumé, and a sample of completed employment applications. One youth did not receive a state issued identification card due to the mobile Department of Highway Safety and Motor Vehicles not being able to be on-site due to COVID-19 pandemic. There was no documentation to support the exit portfolio was provided to the youth or juvenile probation officer upon release for all three youth case management records.

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

The program has a policy and procedures to address the requirements for each youth's exit conference. Three closed youth case management records were reviewed for exit conferences. Reviewed documentation indicated the exit conferences were conducted after the program notified the youth's juvenile probation officer (JPO) of the youth's pending release and at least fourteen days prior to the youth's release date. The exit conference documentation in each of the three records documented the date, signatures or names, if participating by telephone, and a summary of pending transition goals. The youth, case manager, therapist, direct-care staff, a member of management, and a parent or guardian were involved in the exit conference. There was no documentation to support the transition manager participated in the exit conference for all three youth. All records documented the exit conference was conducted separately from the transition and Community Re-Entry Team meetings.

2.22 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 policy and procedures ensuring an on-going safety planning process for each youth; helping identify stimuli which have both positive and negative effects on the youth. At a minimum, the safety plan includes the following areas: warning signs, youth baseline behavior, crisis recognition; debriefing preferences, intervention strategies, and coping strategies, co-developed with youth which outline people and healthy environments defined by youth. The program maintains a safety plan binder, located in master control, and is easily accessible to all staff. The binder contains safety plans for each youth in the program and is updated every thirty

days for each youth. Also, a safety plan is kept in the individual mental health record of each youth in the program.

Five youth mental health records were reviewed. Each youth mental record contained a current safety plan. Each safety plan was completed within fourteen days of youth admission and was jointly developed by youth, parent/guardian, program clinical staff, and behavior specialist, if applicable. All five safety plans contained the required information and incorporated any recommendations from previous or current clinical assessments, and incorporated trauma responsive practices. Safety Plans are available and are reviewed by staff who have contact with youth. In May 2020, safety plans were updated removing the treatment teams' signatures, just leaving the youths and therapists signatures. This change enabled the review team to determine if a collaborated team effort was involved in the development and thirty day review of the safety plans. Five youth were interviewed and all five stated they were involved in the development of their safety plan. Five staff were interviewed and all five stated the location of the safety plan binders is in master control and they knew the process for reviewing safety plans.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed clinical social worker (LCSW) who serves as the designated mental health clinician authority (DMHCA). The DMHCA is employed full-time by the program and is on-site at least forty hours a week. They are available twenty-hour hours a day, seven days a week in the event of a mental health or substance abuse emergency. A review of the DMHCA's license found it to be clear and active, with an expiration date of March 31, 2021, under Chapter 451. An interview with the DMHCA reflected they are responsible for ensuring the timely and accurate completion of the required assessments, evaluations, and treatment plans. In addition, the DMHCA ensures the treatment programming at the program complies with all requirements outlined in the program's contract. The program will utilize the provider's training director, who is also a LCSW, to provide coverage in the absence of the DMHCA for the program. A review of their license found it was clear and active and expires March 31, 2021.

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

The program has a licensed clinical social worker (LCSW) who serves as the designated mental health clinician authority (DMHCA). A review of the DMHCA's license found it to be clear and active, with an expiration date of March 31, 2021. The program will utilize the provider's training director, who is a licensed clinical social worker, to provide coverage in the absence of the DMHCA for the program. A review of their license found it was clear and active and expires March 31, 2021. The program has a part-time licensed mental health counselor (LMHC) who is available to assist, if needed, in the absence of a non-licensed clinician. A review of their license found it is current and active and expires March 31, 2021. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of April 7, 2021.

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

The program has a policy and procedures to ensure metal health and substance abuse staff have the appropriate credentials. The program has two full-time non-licensed clinicians who provide services to youth in the program. Schedules are staggered to ensure the program has clinical staff present seven days a week. Each of the non-licensed clinicians hold a master's-level degree in a relevant field of study. A review of direct supervision logs for the past six months confirmed all applicable non-licensed mental health clinical staff were provided with at least one hour on-site face-to-face direct supervision by the designated mental health clinician authority (DMHCA), or their backup, each week they worked, with no exceptions. The program was able to provide documentation of twenty hours on-the-job-training in assessing suicide risk, mental health crisis intervention, and emergency mental health services for each of the non-licensed clinicians. The reviewed documentation validated the administration of five Assessments of Suicide Risk (ASR) conducted in the physical presence of a licensed mental health professional, which allows them to conduct ASRs and prepare them for approval by a licensed clinician.

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

The program has a written policy and procedures which explain their comprehensive screening process conducted on each youth at admission. A review of documentation confirmed they follow the procedures outlined in the policy. A clinician completes a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) on each youth as part of their admission process. The reviewed documentation in all five records confirmed this assessment was completed on the day of admission by a clinician and was entered into the Department's Juvenile Justice Information System (JJIS). Each of the reviewed MAYSI-2 instruments were conducted by trained staff. Reviewed documentation confirmed all available information was reviewed to ensure they get a clear picture of the youth's history. The reviewed documentation included each youth's Pre-Disposition Report (PDR), their most recent Community Assessment Tool (CAT) Full Assessment, and any available psychiatric/psychological reports prior to their arrival and/or during the admission process.

The program's practice is for each youth to be screened using an Assessment of Suicide Risk (ASR) and for each youth to be referred for a new comprehensive mental health and substance abuse evaluation regardless of their scores on the MAYSI-2. This practice was confirmed as three of the five reviewed MAYSI-2 instruments indicated a need for further assessment, and each of the youth were referred for a new comprehensive mental health and substance abuse evaluation by a clinician. Additionally, one of the youth had concerns of suicide ideation identified; however, each of the youth still had an ASR completed the day of admission as part of the program's assessment process. Interviews with the facility administrator and designated mental health clinician authority (DMHCA) confirmed the program's admission process.

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

The program has a policy and procedures defining how they will complete a new Comprehensive Mental Health/Substance Abuse Evaluation. Three of the five reviewed youth mental health records included a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), all three indicated a need for further assessment upon entry to the program. All five of the reviewed mental health records confirm each were referred for an evaluation, as this is the program's practice. All five youth had a new Comprehensive Mental Health/Substance Abuse Evaluation completed within thirty calendar days of admission. All were completed by a non-licensed clinician, and each had a review by a licensed clinician the day they were completed. Each reviewed assessment 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, Fifth Edition (DSM-5) diagnosis, summary of clinical impressions, and treatment recommendations. The results of the Comprehensive Mental Health/Substance Abuse Evaluation are used to assist in developing 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.*	

Each youth is assigned to a treatment team on their day of admission. A review of five youth case management records found the specific assignment of a case manager and a therapist to each youth on their classification form, which is completed at their classification meeting on the day they are admitted to the program. The program's policy designates who will serve as the remaining members of each youth's treatment team, to include a member of program administration, a living unit representative, nursing staff nurse, education staff, and the parent/guardian, when applicable.

Observations by a review team member and the review of treatment team documentation confirmed the team consisted of all required members. The mental health and substance abuse daily service progress notes for all five youth were reviewed. The progress notes were documented on a form which contained all the information found on the Department's Group Progress Note form. This review confirmed all five youth received services as set forth in their individualized treatment plan, with no exceptions being found. All five of the reviewed youth had a copy of a properly executed Authorization for Evaluation and Treatment (AET) in their Individual Healthcare Record (IHCR). Each of the five reviewed records contained a signed

Youth Consent for Substance Abuse Treatment form, and a signed Youth Consent for Release of Substance Abuse Treatment Records form. A review of all five youth's mental health and substance abuse daily service progress notes, as well as group sign-in sheets, validated mental health groups had no more than ten youth present, and substance abuse groups had no more than fifteen youth in attendance during any group sessions. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of April 7, 2021.

An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides mental health and substance abuse treatment groups, family counseling, individual counseling, and psychosocial skills training. The DMHCA indicated treatment groups are conducted seven days a week, individual counseling occurs no less than once a week for each youth, and family counseling is scheduled at least once a month for each youth. Five youth were interviewed, and each of them confirmed participation in group activities. Group curricula mentioned were VOICES, Impact of Crime, Thinking for a Change, Teen Relationships, and Reaching Out. Four of the five youth indicated they have learned new skills from attending these groups. Some of the new skills they mentioned were patience, how to respect others, ways to express their feelings, coping skills, and how to accept criticism. Three of the youth reported being able to practice some of these skills outside of the group sessions. All five interviewed youth confirmed they receive both individual counseling one time a week, and four indicated they have a family counseling session at least once a month. Four of the five interviewed staff all indicated they do not facilitate mental health or substance abuse treatment groups. The other respondent was a therapist who does facilitate groups with the youth. They confirmed no direct-care staff facilitate any mental health or substance abuse groups for the youth.

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

The program has a policy and procedures which establish how they complete treatment planning for all youth. All five reviewed mental health and substance abuse records contained an initial treatment plan which was completed on the day of admission. All were completed on a form which contained all the elements of the Department's Initial Mental Health/Substance Abuse Treatment Plan form and were signed by all treatment team members. One was completed by a non-licensed clinician, and clinician and was reviewed by the designated mental health clinician authority (DMHCA) within ten days of completion. The remaining four were completed by the designated mental health clinician authority, and authority and required no further review. Four of the five records contained an individualized treatment plan which was completed within thirty days of admission. The other plan was completed three days late. Each plan was signed by the treatment team and reviewed by the DMHCA within the required ten-day

time frame. These were completed on a form which had all required elements found on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form.

The individualized treatment plans included any psychiatric services, including psychotropic medications and the frequency of monitoring by the psychiatrist, when applicable. Each of the youth had treatment plan reviews which were completed every thirty days, as required. Three closed records were reviewed for youth released from the program. There was evidence the program completed a Mental Health/Substance Abuse Discharge Summary in each reviewed record. Each was found to include recommended services for the daily maintenance of the positive improvement in behavioral, emotional, and social skills made by the youth during treatment. The reviewed documentation confirmed these plans were discussed and finalized at the exit conference for each youth. Reviewed documentation in the closed records could not confirm any of the Mental Health/Substance Abuse Summaries were provided to the youth, parent/guardian, or the juvenile probation officer (JPO) following their release from the program.

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

The program's contract requires them to provide Mental Health Overlay Services (MHOS) for all youth in the program. They have a policy and procedures which address the provision of these services to all youth in the program. A review of five youth mental health and substance abuse records confirmed the program provides groups session five days a week. Individual and family sessions are held with youth as prescribed in their individualized treatment plans. Daily therapeutic activities are provided seven days a week by the program's clinical staff. A review of documentation confirmed the psychiatrist is on-site at least bi-weekly, with no exceptions. The review of records confirmed youth with co-occurring substance abuse disorders receive substance abuse treatment services. A review of group progress notes, program schedules, and youth interviews confirmed clinical staff were at the program seven days a week. The program does not have a contract with a psychologist, as this position is not required in their contract. The counselor and therapist caseloads are currently at seven and nine youth, respectively. If the program is at capacity, twenty youth, the caseloads would be ten youth each as confirmed through an interview with the designated mental health clinician authority. The interview confirmed their provision of MHOS.

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

The program has a contract with a licensed physician (MD) to provide psychiatric services. The MDMD is certified by the American Board of Psychiatry and Neurology in Child and Adolescent Psychiatry. The license is clear and active, with an expiration date of January 31, 2021. The program has a medical doctor (MD) with a clear and active license expiring on January 31, 2022 who serves as the backup for the psychiatrist. Both are licensed under Chapter 458.

A review of five youth mental health and substance abuse records revealed four of the youth were admitted on psychiatric medications. Program practice is for each youth, regardless of whether they require psychotropic medications, to be referred to the psychiatrist for an initial diagnostic psychiatric interview. The review of youth records confirmed each of the five youth was seen by the psychiatrist within the required time frame. Each initial psychiatric diagnostic interview was completed using the program's initial psychiatric evaluation form, which contained all required elements, and incorporated page three of the Department's Clinical Psychotropic Progress Note (CPPN) form. Whenever new medications were prescribed, adjustments to dosage were made, or medications were discontinued page three of the CPPN was used. This form was completed in its entirety and contacts with the parent/guardian were seen when applicable. All required medication management appointments were completed monthly for each of the four applicable reviewed youth. One of the reviewed youth was applicable for Tardive Dyskinesia screening. The program provided documentation reflecting this monitoring was completed monthly.

The program's contract and Mental Health Overlay Service requirements indicate the psychiatrist must be on-site bi-weekly to provide services to the youth. The agreement with the program states the psychiatrist will provide services for a minimum of two hours on a bi-weekly basis, and they must be available twenty-four hours a day, seven days a week for consultation. A review of psychiatric service logs found the psychiatrist, or their backup, were on-site at least bi-weekly for at least two hours during the previous six-month period. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the psychiatrist validated they provide services weekly to include evaluation, medication management, consult liaison with medical staff, psychotherapy, and psychoeducation. The psychiatrist indicated there is good communication with the program, and they have a meeting with all available clinical staff during each visit. The psychiatrist indicated they have no concerns with the healthcare or mental health and substance abuse services provided at the program.

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

The program has a written suicide prevention plan detailing the program's suicide prevention procedures. The plan contains all the required elements outlined in the Florida Administrative Rule 63N and includes how the program will safely assess and protect youth with elevated risk of suicide in the least restrictive means possible. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, level of supervision, referrals, communication, notification, documentation, immediate staff response, and a review process. The plan had its annual review completed by the facility administrator (FA) on July 2, 2020. The last review by the designated mental health clinician authority (DMHCA) was completed on July 15, 2019. After this discrepancy was revealed to the program, the DMHCA signed the plan to indicate their review on November 3, 2020. They provided a statement which indicated the FA and DMHCA had reviewed this plan on July 27, 2020.

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

The program has a suicide prevention plan in place which outlines the methods used for supervising, observing, monitoring, and housing for youth identified through screenings, review of available information, or staff observations as having suicide risk factors. A review of five youth mental health and substance abuse records found each youth was screened for suicide ideation during their admission to the program. One of the five reviewed youth had a "hit" for suicide ideation on their MAYSI-2; however, it is program practice to conduct an Assessment of Suicide Risk (ASR) on each youth during the admission process, regardless of whether any suicide risk factors were identified.

Each of the five youth, four of whom had no risk factors, were evaluated during admission, confirming the program's practice. Each of these youth had an ASR administered on their day of admission, and four were maintained on standard supervision. The other youth was maintained on constant supervision and was stepped down following the program's suicide prevention plan. One of the five ASRs was completed by a non-licensed clinician under the supervision of a licensed clinician, while the other four were completed by the designated mental health clinician authority (DMHCA).

The review of the youth records revealed three of the youth had been placed on suicide precautions during their time at the program. A total of five examples from these three youth were selected and reviewed for these youth. Three of these were a result of the youth self-reporting feelings of possible self-harm, one was due to staff observations, and the other arrived to at the program while on precautionary observation. Each youth had an ASR completed within twenty-four hours of the youth being identified as at risk. Supervision for all the applicable youth was documented on a Suicide Precautions Observation form. These forms were completed in their entirety, to include the identification of "safe housing areas." A review of each ASR reflected notification was made to the youth's parent/guardian and their assigned juvenile probation officer (JPO), regardless of whether the youth was maintained on suicide precautions or not. None of these instances resulted in the youth being immediately stepped down to standard supervision after administration of the ASR.

Each youth was seen for a Follow-up Assessment of Suicide Risk each day they were on precautionary observation, until the decision was made to step the youth down to close supervision. Each youth was stepped down from close supervision through the completion of a Mental Status Exam, according to the program's policy. The documentation reflected a conference with a licensed clinician, when completed by a non-licensed clinician, and the facility administrator/designee prior to reducing the level of supervision in each instance. This was clearly documented on each reviewed ASR or Follow-up Assessment of Suicide Risk form, and the DMHCA signed the form the next time they were on-site, when required. During these

youth's heightened placement, supervision was documented using Suicide Precaution Observation Logs and Close Supervision Logs. No lapses in supervision were observed on the reviewed logs. Documentation reflecting the placement status of the youth was found in the master control logbook, and in the Department's Juvenile Justice Information System (JJIS) alerts. All JJIS alerts were entered and closed appropriately.

Two youth of the five reviewed youth records had evidence these youth were placed in secure observation during this annual compliance review period. Each youth had one placement. The program was able to provide another example for a youth who was placed into secure observation. The reviewed documentation for each of the instances revealed placement was authorized by the DMHCA. The program has two rooms designated for secure observation. Each of the youth had a Health Status Checklist, completed by a member of the same gender, for each placement. The reviewed Suicide Precautionary Observation Logs reflected both the youth and room were searched prior to the placement. Each of the youth were on constant supervision while maintained in secure observation. Each youth had an ASR conducted within eight hours of placement. In each instance, the decision was made to remove the youth from secure observation and place them back on precautionary observation with constant supervision. Support services were provided, when applicable, and each step down was completed after conferring with the facility administrator/designee and the DMHCA, when applicable. All placements and status changes for youth on any type of heightened supervision are maintained in the master control logbook.

The review of logbook documentation found discrepancies with the documentation for two instances of precautionary observation being communicated appropriately. The reviewed documentation for one youth reflected they failed to document the youth being on constant supervision for three applicable shifts in the "Communication Board/Alert Status Review" section. The documentation for the second youth reflected nothing for the second shift on August 8, 2020. The logbooks for this shift were found to be blank, with nothing having been recorded except for one staff name on the pages of the pre-printed logbook. The program indicated they maintain this information through other means, and review alerts using the alert board during the shift briefing process.

The program has one suicide response kit which is kept in the large multi-purpose room. The kit was found to include a knife-for-life, wire cutters, and needle nose pliers. Four of the five interviewed staff indicated the suicide response kit was maintained in the multi-purpose room, while all five indicated one is maintained in master control. Interviews were conducted with five staff regarding what they are responsible for if a youth expresses suicidal thoughts. All five indicated they will notify the program's clinical staff, place the youth on constant sight and sound supervision, and document their supervision of the youth. Two of the staff indicated they would complete a mental health referral for the youth. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, facility procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services.

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 review of five youth records found three of the youth had been placed on suicide precautions which required the completion of Suicide Precaution Observation Logs. There were twenty-eight logs available for review for these youth. All logs were maintained for the duration the youth was on suicide precautions, and the staff documented the youth's behavior in real time at intervals which did not exceed thirty minutes. All reflected warning signs were documented after notification was made to the designated mental health clinician authority and the facility administrator/designee. Each of the reviewed Suicide Precaution Observation Logs had all required reviews by supervisory staff and licensed clinicians. Additionally, the program prints the Suicide Precaution Observation Logs on orange paper making them more noticeable for staff. Informal interviews were conducted with three youth who had been on suicide precautions during their stay. Each of the youth indicated staff were with them always during this placement, and they were never left alone while on suicide precautions.

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

The program's suicide prevention plan addresses suicide prevention training. A review of five in-service training records found each staff received at least six hours of suicide prevention training. The program's mock suicide drills were reviewed since the last annual compliance review. This period included the last quarter of calendar year 2019 and the first three quarters of calendar year 2020. Each of the drills included the time of the drill, the designated shift, name of the staff who conducted the drill, the nature of the incident, persons involved/function of each, type of medical care given, type of mental health/crisis intervention provided, the outcome of the incident, the time of response, and any follow-up or corrective action needed. The review also found each drill had a sign-in sheet attached with the names and signatures of all staff who participated in the drill.

The facility is currently operating with three different shifts. A review of drill documentation found at least one mock suicide drill was conducted on each shift for the previous four quarters. The mock suicide drill training documentation supported all twelve reviewed staff participated in drills, as required. While two of the mock suicide drills included the demonstration of cardiopulmonary resuscitation (CPR), the review of medical drills confirmed CPR was covered in their drills at least once each quarter to allow staff to practice these skills. A review of monthly all-staff meetings reflected some of the drills are reviewed during these meetings; however, the reviewed documentation reflected the frequency in which the drills were held allowed for staff to meet the semi-annual drill participation requirements. Interviews with five staff confirmed suicide and medical emergency drills are conducted monthly.

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 comprehensive mental health crisis intervention services plan. The plan ensures the program responds 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 program. The plan contains all the required elements outlined in the Florida Administrative Rule 63N and includes a notification and alert system, means of referral including youth self-referral, communication, supervision, and documentation and review of the crisis. The plan was reviewed and signed by the facility administrator on July 2, 2020, and by the designated mental health clinician authority (DMHCA) on July 27, 2020.

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.	

Two of the five reviewed mental health and substance abuse records found the youth required the completion of a Crisis Assessment. The program provided the record for the one other youth who was applicable for a Crisis Assessment. Each youth was found to have required the completion of one separate Crisis Assessment during their stay. In each instance, the youth were seen within two hours of being determined to be in crisis, when applicable. Each assessment included the reason for the assessment, a mental status exam and interview, the determination of danger to self and/or others, clinical impressions, recommendations of treatment, supervision levels, and follow-up or further evaluation. One of the youth was elevated to precautionary observation and was placed on constant supervision using a Suicide Precaution Observation Log as a result of the Crisis Assessment. The other two reviewed assessments reflected the youth were maintained on supervision using a Mental Health Alert Log. These youth were stepped down to standard supervision after completion of a subsequent follow-up Mental Status Exam while following the procedures outlined in their Crisis Intervention Plan. The plan includes procedures for the notification of the youth's parent/guardian, which was completed for each of the reviewed assessments. All three assessments were either completed by a licensed clinician or a non-licensed clinician, which was followed by a review by a licensed clinician within the required twenty-four-hour period. One of the reviewed crisis assessments was completed due the youth being an alleged victim in a Prison Rape Elimination Act (PREA) event. The review of this assessment found the program completed the appropriate mental

health referral immediately after becoming aware of the alleged incident. All program's procedures were followed, to include mental health staff being available for the youth. A review of the Department's Juvenile Justice System (JJIS) found all alerts were entered, as required.

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

The program has a detailed emergency mental health and substance abuse services plan which addresses mental health and substance abuse emergency care. The plan contains all the required elements outlined in the Florida Administrative Rule 63N and includes the immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, staff training, and a review process for each incident. The plan had its annual review completed by the facility administrator (FA) on July 2, 2020. The last review by the designated mental health clinician authority (DMHCA) was completed on July 15, 2019. After this discrepancy presented to the program, the DMHCA signed the plan to indicate their review on November 3, 2020. They provided a statement which indicated the FA and DMHCA had reviewed this plan on July 27, 2020.

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

The program has a detailed emergency care plan which addresses mental health and substance abuse emergency care. A review of five youth mental health and substance abuse records found two of these youth had been hospitalized pursuant to a Baker Act during this annual compliance review period. The program did not have any other examples for review. The review found the decision for one of the youth was made during the administration of an Assessment of Suicide Risk. Once the decision was made to have the youth transported, they were placed on one-to-one supervision until law enforcement arrived to transport the youth. The reviewed documentation confirmed notification was made to both the designated mental health clinician authority and the facility administrator/designee when the youth was exhibiting their concerning behaviors.

The second youth had been on constant supervision. The program contacted law enforcement due to staff having been assaulted by the youth prior to their placement on constant supervision. When law enforcement arrived to assess the situation, they made the decision to transport the youth pursuant to Baker Act procedures based on statements made by the youth. Upon return from the crisis stabilization unit each youth was maintained on at least constant supervision until they could be seen for an Assessment of Suicide Risk (ASR). Each of these youth were maintained on precautionary observation after the initial ASR and were stepped down following the program's policy and procedure. The program did not have to use Marchman Act procedures during this annual compliance review period.

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 of equal licensure coverage in place for scheduled absences, emergency services, and vacations. The backup MD has a clear and 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 practice registered nurse (APRN) 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. The 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, has three full-time nurses; two registered nurses (RN) and one licensed practical nurse (LPN) with current licenses expiring April 30, 2021 (RN), July 31, 2021 (RN) and July 31, 2021 (LPN), respectively. The program utilizes three additional nurses as back-up, as needed, and all three licenses (two RNs and one LPN) are current with active licensure expiring in April 2021 and July 2021.

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

The program 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 2020. The policies and procedures were reviewed, approved, and signed by the designated health authority (DHA) and the facility administrator (FA) on June 17, 2020. The DHA and FA conducted an annual review of the nursing protocol manual on June 17, 2020. After approval, all medical staff reviewed and signed acknowledgment on the signature page of the program's policy, procedures, and the nursing protocol manual. There were no blanket protocols. The policy related to psychiatric services was signed by the psychiatrist on June 19, 2020. 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 (IHCR) 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. All five youth IHCRs contained an AET 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 another youth was eighteen when admitted. Each of the youth signed an AET for youth eighteen years of age or older in accordance with policy. In all five IHCRs, there were copies of completed parental notifications which were maintained behind the AET in the IHCRs. The sample size did not contain an applicable youth under the care of the Department of Children and Families (DCF). Therefore, the program provided an additional youth under DCF care. The DCF youth record was reviewed and found it contained authorization of all treatment and procedures through a court order.

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 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 (IHCR) 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 consents were documented in the progress notes and written notification was mailed to the parent/guardian in each case. In addition, notifications were 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.

Four 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 four 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.

During interviews with nursing staff, it was stated nursing procedures are to check for youth vaccinations in the Department's Juvenile Justice Information System (JJIS) or contact the juvenile probation officer (JPO) to get an appropriate record, prior to youth arrival. If vaccinations are not up-to-date, then proper consents are obtained, and youth are referred to the Health Department. 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. The sample size did not contain a youth under the care of the Department of Children and Families (DCF). Therefore, the program provided an additional youth record under DCF care. However, the DCF youth record was reviewed and found the youth was not prescribed psychotropic medication. Therefore, no youth was applicable for notification to DCF.

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 (IHCR) were reviewed. Each IHCR contained a FEPHS form completed by a registered nurse, on the date of the youth's admission to the program. Two of the five reviewed youth IHCRs contained a change of custody. A FEPHS rescreen was completed for each youth on the date youth were 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 protocols, the nursing department completes all FEPHS on the day of admission. If a change in custody occurs, a FEPHS rescreen 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 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 covers what to do in case of a sexual assault and the non-disciplinary role provided by medical staff. Five youth Individual Healthcare Records (IHCR) 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 of the five youth covered all the required topics to include on 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 (IHCR) 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. 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 (IHCR) 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. According to the nursing staff, medical staff completes the HRH upon admission, annually prior to the CPA, and as needed. Two youth left the custody of the program due to arrests; the HRH was updated when the youth were 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. Three of five youth IHCRs contained a new CPA for each youth at the time of admission. The remaining two youth IHCRs had a current CPA. 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 CPAs confirmed Tuberculin Skin Tests (TST) were conducted within required guidelines and youth were not placed in general population until results were assessed by the program's DHA. Reviewed documentation supported the Department's Problem List for five applicable youth were also updated, as required.

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 (STI) 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 (IHCR) 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 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 IHCRs validated three youth refused (HIV) testing and the required refusal form was signed by youth and filed in each IHCR. The remaining two 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, the youth's signature documented on the outside of the envelope filed in the laboratory test section of the IHCR. The program does not include HIV status as part of the internal alert system. All 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 policy and procedures 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 11:20 a.m.

through 11:50 a.m., seven days a week and are posted above the sick call box at the nurse's office, the multi-purpose room, and the master schedule. 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) and youth in confinement are questioned daily for any health complaints. 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. All five youth were applicable for completed sick call requests. All youth were seen within four hours of submitting the request. All 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.

One youth submitted a sick call during the annual compliance review and was observed. The youth was escorted by a trained youth care worker; the youth provided verbal consent; the medical provider identified themselves and stated why youth was there; the youth's privacy and confidentiality was maintained; the youth was examined by a registered nurse, while trained staff remained outside the exam room door; and the youth signed they were seen.

Five interviewed staff indicated sick call is held once a day and sick call and medication administration is performed by a RN and each of the staff can call 9-1-1 when necessary. Five interviewed youth indicated they are allowed to see a dentist and doctor when needed and medications are administered by the nurse. Youth interviews indicated two were seen immediately by the nurse, two were seen within a day by the nurse and one was seen within three days by the nurse when submitting a sick call request. In an interview, the nurse stated youth are evaluated within two to four hours after making a sick call request and sick call requests are triaged for immediate care, as needed.

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 policy and procedures 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 9-1-1 and have current certifications in first aid, 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 May 2021. 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. AED checks were reviewed since the program's last annual compliance 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 Care 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 response kit located in master control. The first aid and suicide response kits 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 the documentation, were legible, and meets the requirements. The Episodic Care Logs were reviewed for six months and compared with on-site and off-site events in the youth's Individual Healthcare Record (IHCR) and were matching.

Medical drills were reviewed for the previous twelve month period. The drills are conducted quarterly on each shift and include CPR, at least annually. All drills were found to be documented in the facility logbooks. The automated AED was brought to the drills by staff; and documentation confirmed use. All five youth interviews indicated yes, they can see a dentist or doctor when requested. All five staff interviews indicated staff can call 9-1-1 if a youth has a medical emergency.

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 policy and procedures to provide timely referrals, coordination, and documentation of medical services to off-site health providers for youth with emergent or non-emergent needs. Two of the five records reviewed were applicable for off-site health services. In each of the two records, the parent/guardian was notified of the need for services; a summary of the services was filed in the youth's Individual Healthcare 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 policy and procedures to ensure youth with chronic conditions receive regular evaluations and the necessary follow-up for care. Five youth Individual Healthcare Records (IHCR) 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. 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 Department's Problem List and progress notes.

Two youth were 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 two applicable youth were seen by the DHA for off-site follow-up services. There was no lapse in services for any youth on-site or off-site. The Department's 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, a tracking system is utilized through the Problem List update and progress notes. During an interview, the facility administrator stated the program meets daily with medical staff, during administrative meetings and at quarterly DHA meetings to review important medical issues pertaining to youth in the program.

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 policy and procedures 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 has 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 Healthcare 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 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.

Four of the five of the IHCRs reviewed were applicable for receiving medications. All four 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(s)/guardian(s) are notified. All four youth had a current and valid order for the medications. One youth in a medication pass was observed during the annual compliance review. The one 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. According to the registered nurse, the process to dispose of expired medications is to record the medication on the Quarantine/Unusable Medication Log and twice a month return any unused medication to the originating pharmacy; any medication which cannot be returned is destroyed monthly, with two nurses present, using RX Destroyer. Four of the five interviewed youth indicated medications are administered by the nurse. The remaining one youth stated not receiving medication. 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 no discrepancies. The program stores documentation of all disposals in a binder for medication management. The program has a separate refrigerator for medications; labeled biohazard and secured. The nursing staff interview indicated the medication inventory is locked and perpetual and weekly inventories are maintained as well as their practice to secure controlled substances, such as narcotics by using double locks on the medication cart.

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 policy and procedures 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 include risk assessment and methods of compliance which is located in master control and available to all staff. The procedures were last reviewed and signed on June 17, 2020 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 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 post-partum. In the reviewed Individual Healthcare Records (IHCR), documentation supported a licensed nurse provided in-service education annually to non-healthcare staff which includes monitoring and observation. The designated health authority (DHA) provides a medical evaluation of the pregnancy every thirty days. There was no youth applicable for prenatal care since the last annual compliance review. 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.

4.19 Licensed Medical Staff (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according DJJ Rule as well as Facility operating procedures and nursing protocols approved by the DHA.	

A review of the program's policy and procedures reveal the program is in accordance with the Department's Rule and contract requirements. Daily clinical care is performed by licensed medical staff; by registered nurses (RNs) and licensed practical nurses (LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management, and other assigned duties according the Department's Rule as well as Facility Operating Procedures and nursing protocols approved by the designated health authority (DHA). Documentation confirms the licensed nurses are practicing within the Florida Nurse Practice Act and the applicable Florida Board of Nursing Rules. The program has on-site nursing coverage which is being provided by RNs or at a minimum, LPNs. Documentation confirms the licensed healthcare professional providing the direction to the LPN is responsible for reviewing all medical records daily with the LPN and be available on-call for consultation. Documentation confirms the nurse licensure credentials and cardiopulmonary resuscitation (CPR) certifications are clear and active. The contract requirements are in compliance with specific duties outlined in the contract.

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 and procedures dictate staff-to-youth ratios of; one to eight during awake hours, one to twelve during sleep hours, and one to five for off-site activities, visitation, or when separated from the population. During the four day annual compliance review, multiple observations of supervision were made each day. Program staff were observed supervising youth during school hours, in the cafeteria, upon return from a youth transport, and youth movement through the facility.

Staff were observed supervising youth during school hours, in the cafeteria, in group sick call, and youth movement through the facility. Staff were observed to be following the amended ratio requirement. The shift supervisor was able to give the total youth count when asked. A video review of supervision during sleeping hours found the required staff-to-youth ratio was maintained during sleeping hours. The daily schedules were posted in the dorm and cafeteria. The program has a full schedule of activities planned and youth were observed engaged in the activities. Staff were observed escorting youth from one location to another. At no time during the annual compliance review were youth observed wandering freely about the program.

Each of the five interviewed staff confirmed their understanding of the procedures when there is a discrepancy with the count. All the staff indicated the count is reconducted until the count is reconciled. Observations found the counts were conducted at scheduled and unscheduled times and the shift supervisor was able to give an accurate count when asked.

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 policy and procedures which governs the program's behavior management system (BMS) or positive performance system (PPS), which fosters accountability for behavior and compliance with the residential community's rules and expectations. The PPS was observed posted in the multi-purpose room, master control, and in both youth pods.
The PPS is clearly explained in the resident handbook, which is accessible to youth. The program's PPS details the rules and the positive and negative consequences for actions. The PPS system does not allow for increased length the of stay, the denial of youth basic rights, group punishment, youth on youth punishment, and disciplinary confinement as a consequence. Positive incentives are offered on a daily, weekly, and monthly basis to encourage youth to progress. The orientation checklist documents the PPS is reviewed with the youth. The PPS is

outlined in detail within the youth handbook, which, reviewed documentation showed all five youth received a copy upon intake.

All five reviewed youth case management records contained a complete orientation checklist. The PPS promotes youth rights, positive and negative consequences, constructive disciplinary action, opportunities for reinforcement, positive dialogue, and peaceful resolutions as well as provides youth with pro-social acceptable alternative behavior, maintains order and security, and minimizes the separation of youth from the population. Youth have an opportunity to explain their behavior. The PPS is connected to each youth's individual performance and treatment plan goals. The PPS includes a variety of rewards including daily snacks, boutique (point store), verbal praise, special privilege activities, and off-campus incentive trips. Hillsborough Girls Academy implemented a Phenomenal Woman, this is for the youth to recognize women which have impacted them in a positive manner. The Phenomenal Woman can be family, staff, and/or youth. Student of the Month Award is based on the votes of the staff and youth. The Student of the Month winner will receive a Meal with Staff Award and are encouraged to invite a peer to attend. There is a Most Improved Youth Award which comes with an added incentive such as a meal with staff, being given a new hairstyle, tie dying shirts, receiving a manicure, and extra boutique (point store). An award ceremony will be held on the third Wednesday of each month, at the end of the all staff meeting, so all staff can attend. Youth on Grace, which is the highest level, will be eligible to be a part of creating level shirts and sweatshirts for the youth who level up. The facility administrator interview confirmed the PPS is a level/point system with daily, weekly, and monthly incentives. Point cards and levels are reviewed by administration daily during morning management meetings. Five pre-service training records and five in-service training records were reviewed and indicated all staff training records contained PPS training.

All five interviewed staff confirmed training and understanding of the PPS. Informal interviews with staff during the annual compliance review week confirmed their understanding and implementation of the PPS. Five youth were interviewed about the PPS. Four interviewed youth rated the PPS as good and one youth rated the PPS as fair. All five youth stated they have a good understanding of the PPS and all five knew the rewards and incentives they can receive for positive behaviors.

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.*	

According to the policy and procedures, implementation of the program's positive performance system (PPS) should maintain order and security, provide constructive discipline, and provide a system of both positive and negative reinforcements to encourage the youth. The assistant facility administrator generates the point cards based on the youth's accomplishments or setbacks and distributes the updated cards to staff. At the end of each week, the point sheets

are filed in each youth's case management record. The program's PPS does not include increasing a youth's length of stay, denial of basic rights, promotion of group punishment, or disciplinary confinement. The program's PPS includes a process wherein staff explain to the youth the reason for any sanction imposed. Youth are given an opportunity to explain their behavior, staff and the youth discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternative acceptable behavior. Youth and staff interviews confirmed their thorough understanding of the PPS.

The facility administrator (FA) interview confirmed rewards are offered on daily, weekly, and monthly basis and youth progress is tracked daily. The program tracks the number of youth making their day/week in the PPS database. The FA interview confirmed consequences are monitored during the morning management meeting, as well as during special and regular treatment teams. All five interviewed youth confirmed they are never punished by other youth. Positive and negative behaviors are reviewed during treatment teams. Each of the five interviewed staff indicated they received feedback on their implementation of the PPS daily and as needed. All five interviewed staff confirmed training and understanding of the PPS and indicated there are a variety of rewards and incentives for good behavior. All five stated the PPS is discussed during staff meetings monthly.

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 thirty-seven cameras which provide video surveillance of the facility. All thirty-seven cameras were operational at the time of the annual compliance review. The surveillance system is capable of retaining thirty days of video recordings. Corresponding video surveillance and ten-minute check sheets were reconciled compared for seven nights to determine compliance.

All seven ten-minute check sheets reviewed contained the date, time, and initials of the staff. Reviewed video and documentation confirmed staff conducted the checks within the ten-minute window in call cases. Five staff were interviewed; all five staff indicated room checks are completed every six to ten-minute increments. The facility administrator interview confirmed the program has thirty-seven cameras with video coverage stored for thirty days. Master control interview confirmed the standing practice is for all staff to conduct youth visual checks in six-minute increments to ensure compliance with the ten-minute time frame.

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's policy and procedures address census, counts, and tracking. Observations throughout the week of the annual compliance review confirmed counts were completed in accordance with the program's policy and procedures. The program tracks daily census information including the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program in the logbook. Logbooks for the previous six months were reviewed and found no discrepancies with counts or census. Scheduled and unscheduled counts were observed during the annual compliance review and all counts conducted were conducted accurately and documented correctly. All five interviewed staff confirmed staff know the procedures for reconciling the count if there is a discrepancy and when emergency counts are conducted.

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 which address logbook entry and shift report documentation requirements. All logbooks showed all entries were in ink. None of the pages were removed or obliterated. Each logbook covers a one-month period. The logbook pages are pre-printed shift reports. The first page of each shift contained staff signatures, certifying staff reviewed both current and previous shift information. The logbook pages documented perimeter checks, weather alerts, emergency situations, Central Communications Center (CCC) reports, shift summary notes, incidents, Protective Action Response (PAR) incidents or times when mechanical restraints were used which is not applicable for this program, transports, law enforcement, the Department of Children and Families visits, admissions and releases, youth removed from the mainstream population, escapes or attempted escapes, keys, radios, drills, Prison Rape Elimination Act (PREA) checks, fire safety, scheduled and unscheduled counts, any calls made to the Florida Abuse Hotline, and CCC. Incoming staff review the previous two shifts and the review is documented in the logbook. There were minor exceptions noted where staff conducted logbook lineouts without initial and dating next to the correction. The separate census count template was left blank on August 24, 2020; however, logbook entries reflected

counts being conducted for the day. The second shift of August 2, 2020 logbook section was left blank with no documentation in the logbook for the shift. The program offered additional documentation to reflect entries were done at the facility to capture daily events, however, logbook entries for the shift were not completed. This was determined to be a single incident and not systemic in nature. In the front of each logbook, there is a page for documenting weekly management reviews of the logbooks.

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's policy and procedures addressed distribution, tracking, storage, and overall control and security of keys. A review of the key inventory matched the key rings in use. The keys are kept in a secured cabinet in master control which is not accessible to youth. Each set of keys has an assigned numerical key hook. Keys are assigned to staff according to their department. Restricted keys, temporary keys, and visitor keys are all kept separate from each other. There were no reports of broken or damaged keys. There were no incidents of lost keys, which corroborated by the review of internal incident reports and Central Communications Center (CCC) reports. The physical plant manager is responsible for replacing broken or damaged keys. Key control logs were reviewed for the past six months. Key logs documented the issuance and return of keys on a consistent basis. A random check of three staff key rings confirmed the keys issued matched the key inventory.

All observations during the annual compliance review week found personal keys were secured and staff were aware of program keys in their possession. Observations of key control were conducted while on-site. In all instances, personal keys were turned in, staff key rings were issued, and documentation completed as required. Informal interviews with staff confirmed staff's knowledge of the key rings and assigned keys. All five interviewed staff confirmed staff knowledge of and implementation of key control policies and procedures. Additionally, staff reported if keys were damaged, they would notify their supervisor and submit a maintenance request. An informal interview with the master control operator indicated personal keys are turned in upon entry, restricted keys are kept apart from non-restricted keys, and permitted staff can access restricted keys. Master control tracks keys as they are signed out and back in by staff prior to receiving their personal keys.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program has a policy and procedures designed to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and youth. The contraband measures are detailed program's policy and procedures and the resident handbook. The policy states any staff who is found in possession of contraband in a program will be subject to disciplinary action up to, and including, dismissal, as well as procedures regarding notification of law enforcement for items considered illegal as defined in Florida Statutes. The program defines items and materials considered contraband when found in the possession of youth. The resident handbook provides youth with a list of contraband and informs youth of the consequences if found with contraband. The prohibited list includes personal cellular telephones, equipment and/or electronic devices capable of taking pictures, and/or audio/video recordings, which are prohibited in the secure area. The contraband notice is posted on the front gate and states law enforcement will be contacted for anyone bringing in contraband. All searches are documented in search binders (visitation, room, and youth). The binders were reviewed and found searches were documented appropriately. There were no incidences of introduction of contraband documented during the annual compliance review period. Staff and supervisory staff were able to explain the contraband procedures. Interview with the facility administrator indicated, found contraband items would be logged and either disposed, returned, or turned into law enforcement officials.

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 addressing searches. Observations during the annual compliance review found searches were completed prior to and after movement from one area to another as youth progress through the schedule of the day. A transport observation was not observed during the annual review as no transports were conducted. On-site observations found searches are conducted by same gender staff in manner which treated the youth with dignity and respect. Searches were conducted in accordance with Protective Action Response (PAR) training manual. All five interviewed youth indicated searches are competed after every

movement, off-campus trips, outdoor activities, when items are missing, after visitation, and after meals. All five interviewed staff reported searches are conducted before and after every movement.

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

The program has a policy and procedures which establish transportation requirements which ensure appropriate vehicle maintenance and operated in a safe manner. The program utilizes two vans in conducting transportation services for the program. Both van binders contained a current annual safety inspection. Both vans were observed to be locked when not in use. The two vans used for transports contained a fire extinguisher, seat belt cutter, window punch, and appropriate number of seat belts. Each van had an assigned first-aid kit and emergency kit which is accounted for in master control, as required. No youth transport observations were made; however, interviews of transportation staff indicated both staff and youth must wear their seatbelts, doors secured from inside accessibility, and the presence of a safety screen which separates the main cabin from the driver. A check of all the cars in the parking lot found all the cars were locked.

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's policy and procedures were reviewed and found to ensure compliance of all requirements outlined by the Department relating to transportation of youth and driver eligibility. A check of all cars in the parking lot found all cars were locked. No transport observations were conducted during the annual compliance review. Transportation staff were interviewed which reflected a two staff to one youth ratio on the transports. An approved driver list was observed posted in the master control with staff who have current valid driver's licenses. The transport binder was reviewed. All transport orders were filled out and documented searches and vehicle's safety, ratio maintained during transports, cellular telephone, first-aid and emergency kit, and transporters with one of same sex as youth. Five youth were interviewed about transports, and all youth said they have never seen anyone place contraband in a transport vehicle and they feel safe while in the vehicle. All five staff interviewed and confirmed youth are not transported in staff's personal vehicles. All staff reported they are issued a facility cellular telephone, first-aid kit, emergency kit, and the vehicle are searched prior to the transport for contraband. Staff indicated they are to maintain a one staff to five youth ratio; however, transports must have a minimum of two staff with one being of the same gender. Transporting staff were able to explain what they are required to do in the case of an emergency.

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 which designates the physical plant manager as the person responsible for conducting the weekly safety and security audits in an effort to ensure a safe and secure physical plant, grounds, and perimeter. The audit cover radios, cameras, keys, telephones, mechanical restraints, the generator, flashlights, fire safety equipment, alarms, ensuring no anchor points, youth rooms, recreation area, grounds, correction action needed, and corrective action completed. The weekly safety audits are kept in a binder, which was reviewed. The binder review reflected no missed inspections in the last six-months. The forms contained information regarding safety and maintenance repairs pending, estimated repair dates, and date/time the repairs were completed. Reviewed documentation reflected active engagement by the program to work outstanding issues. All forms were signed and dated by the facility administrator. The interview completed by the facility administrator confirmed the weekly safety audits are conducted in accordance with the program's policy and procedures.

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 policy classifies tools as Class A and Class B tools, with Class A tools having sharp edges and/or considered more dangerous, and Class B tools being cleaning items, such as mops and brooms. 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. All observations during the annual compliance review week found all tools were secured when not in use. Class B tools were in the secured closet in the multi-purpose room. All the Class B tools matched the inventory and picture board in the storage room. The physical plant manager indicated there have not been any reports of damaged or dysfunctional tools. Five staff were interviewed and indicated youth are only allowed to use Class B tools, such as a broom, mop, and scrub brush. Five youth were interviewed and confirmed only tools they have used are mops and brooms.

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

The program has a policy and procedures in place which ensures youth use of tools is conducted in a safe and supervised manner which will prevent unnecessary injuries to staff and youth. The youth orientation checklist informs youth of the rules associated with the utilization of tools and training of proper tool use procedures. Five youth records reviewed found completed orientation checklists for youth, as required. Staff were aware policy forbids disciplinary work projects for youth. Youth do not participate in vocational activities requiring the use of tools. Youth risk assessments are conducted prior to the use of Class B tools and are maintained in a binder. The Class B binder review revealed all forms were completed according to the program's policy and procedures. Each of the five interviewed youth confirmed the youth use scrub brushes, mops, and brooms. All five interviewed staff confirmed youth use mops and brooms.

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 governing an outside contractor or worker entering the program to perform a work project requiring the use of tools. Personal cellular telephones, equipment/electronic devices capable of taking pictures, and/or audio/video recordings are prohibited in the secure area. The program's policy and procedures outline who is responsible for providing approval/permissions if such items are required. The program restricts tools to those necessary, checks tools upon the worker's arrival and departure, restricts youth access to the work area, ensures immediate reporting of any tool the worker cannot locate, and follows-up if any tool is missing. The program maintains a binder which contains all notice of tool equipment instructions forms, which the outside contractor must sign. Review of the binder reflected matching dates of the work invoices matched the sign-in sheets of the outside contractors. The tool notice forms addressed the following: tools checked upon arrival and departure, tool restrictions while in the facility, youth being restricted from the work area, and missing tool follow-up. Outside contractors are required to sign the notice of tool equipment instructions form.

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 which requires emergency response drills are conducted in accordance with the program's disaster plan or Continuity of Operations Plan (COOP) and Facility Operating Procedures. Fire drills are conducted monthly on each shift. The program has been operating on three, eight-hour shifts for the past six-months. All drill documentation included the type of drill, date and time of the drill, participants, brief scenario, and findings/recommendations. Fire evacuation routes and egress plans were observed to be posted throughout the facility. The program has conducted fire, safety, evacuation, and disaster drills during the past twelve months, in accordance with the COOP. All five youth interviewed knew what to do in case of fire and have participated in a drill. All five interviewed staff reported they participate in the following drills: hostage, weather, bomb threat, escape, fire, terrorism, medical, program disturbances, and suicide drill scenarios. The facility administrator interview confirmed the program holds monthly fire drills on each shift, and COOP drills are conducted quarterly on each shift.

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

The program has a policy and procedures which state the Continuity of Operations Plan (COOP) is located in master control and the facility administrator's office. The COOP plan addresses the following planning elements: fire prevention and evacuation, severe weather, program disturbances, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection.

The COOP plan addresses alternative housing plans which was approved by the Department regional director/designee which will ensure continued operations in the event of a relocation. The program conducts COOP drills on each shift. The drill documentation included: type of drill, date and time of the drill, participants, brief scenario and findings/recommendations, and pictures. The drills included escape, missing tools, fire, and evacuation for severe weather. The program has food and necessary supplies readily available in case of emergency evacuation. The program maintains an administrative hard-copy files on youth in case of emergency with all required information which are located in the COOP binder. The facility administrator reported the COOP is located in master control and facility administrator's office area which is accessible to all staff.

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 which regulate the storage and inventory requirements of flammable poisonous, toxic items, and materials. All chemicals were observed to be secured during the annual compliance review. The flammable items are stored in a locked cabinet behind a locked door, in the sally port. Cleaning chemicals are located in locked cabinets, within a locked door, within a lockable storage room. The inventory within the cabinet of cleaning items was both current and accurate. Staff and youth interviews confirmed the youth do not use or have access to chemicals. Safety Data Sheets (SDS) were in each area where chemicals were stored in a binder with a matching picture of the chemical. The SDSSDS matched the chemicals in each storage area. All chemicals were observed to be inventoried as outlined in the program's policy and procedures.

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

The program has a policy and procedures which govern the strict control requirements of flammable, poisonous, and toxic items and materials and youth. The program policy prohibits youth access to chemicals. Observations throughout the annual compliance review week confirmed the youth do not use or have access to the chemicals. The program has a preventive maintenance checklist to ensure the facility is properly maintained. The preventive maintenance checklist is completed weekly by a member of management and maintenance and maintained in the preventive maintenance binder. A review of the preventative maintenance binder found a completed weekly checklist for the six month annual compliance review period. Five youth were interviewed regarding the use of these materials. Each of the five interviewed youth reported they are not allowed to use chemicals. All five interviewed also confirmed youth are not allowed to utilize chemicals.

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 addressing the disposal of flammable, toxic, caustic, and poisonous items are in accordance with Occupational Safety and Health Administration (OSHA) requirements. The policy and procedures identify program positions, titles, or functions authorized to dispose of these items. The physical plant manager is responsible for the disposal of all hazardous waste and/or solid waste and has received training for disposing hazardous items and toxic materials. The program has not had to dispose of any chemicals other than dirty mop water which is emptied into the drain. The program does not use grease for cooking on-site. The physical plant manager indicated if a requirement for disposal presented itself, he would take it to the county's hazardous waste site. The facility administrator reported waste is disposed of safely, at the Hillsborough County Hazardous Waste Collection center, and the item will be documented to include the way it was disposed.

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 has policy and procedures which state the program does not participate in any water-related activities; therefore, this indicator is non-applicable.

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has policy and procedures to allow visitation and communication for youth while in the program. The visitation procedures are posted on the exterior entry way and on the wall in the lobby. The visitation and communication procedures are covered in the resident handbook and covered on the orientation checklist. Each of the five interviewed youth confirmed they have opportunities to contact their family by telephone, mail, and during visitation, during the COVID-19 pandemic. The visitation schedule was posted throughout the program. On-site youth visitation for families was recently reinitiated authorizing youth to have visitors. Program visitation, telephone, and correspondence logs were reviewed. The logs indicated youth had contact with only approved persons. Incoming and outgoing mail is searched and recorded in the correspondence logs. There were no youth applicable for a history of human trafficking according to the Department's Juvenile Justice Information System (JJIS) or Victimization and

Sexually Aggressive Behavior (VSAB) forms; therefore, the program is not required to request clarification from youth's juvenile probation officer (JPO) about any parent/guardian past or current human trafficking investigation involvement.

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 the search and inspection of the controlled observation room. Control observation rooms have been utilized twenty-four times in the past six months. The rooms used for controlled observation met all the requirements. Three controlled observation reports were reviewed. In all three reports, staff documented an inspection of the room and a search of the youth before the youth was placed in the room.

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 for controlled observation. Three controlled observation reports were reviewed. All three reports offered supervisory or higher-level staff authorized placement. In all instances, the youth were displaying active aggression, violent behavior, and/or physically out-of-control. Staff advised the youth the reason of placement in controlled observation and expected behavior for removal. In all three reports, a healthcare professional or staff of the same gender as the youth completed the health status checklist. All three controlled observations reviewed found a duration of less than one hour which does not require program director or designee approval. Three interviewed youth stated they have never been sent to their room as a consequence.

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 releases. Three controlled observation reports were reviewed and all three reports the staff making the placement completed the first page of the controlled observation report in its entirety and submitted it to a supervisor for review. Controlled observation safety checks logged youth checks and details visual observations of youth in fifteen-minute increments as required. Staff documented all safety checks and observations on the Controlled Observation Safety Checks form which was completed on the forms properly. The facility administrator (FA) or designee who has delegated authority gave written approval before the youth was released from controlled observation in all three reports. The controlled observation report, health status checklist, and controlled observation safety checks were maintained in an administrative file. The assistant facility administrator or designee reviewed and approved all three controlled observation reports within fourteen days of the youth's release from controlled observation.