STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Jacksonville Youth Academy
TrueCore Behavioral Solutions, LLC
(Contract Provider)
4501 Lannie Road
Jacksonville, Florida 32218

Review Date(s): March 12-15, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Jill Foy, Office of Program Accountability, Lead Reviewer (Standard 1)
TiAnna Green, DJJ Probation, Juvenile Probation Officer Supervisor, Circuit 5 (Standard 2)
Ben Marrufo, Office of Programming and Technical Assistance, Technical Assistance Specialist (SPEP)
Angela Mills, DJJ Probation, Senior Juvenile Probation Officer, Circuit 4 (Standard 5)
Gwen Nelson, Office of Program Accountability, Regional Monitor (Standard 3)
Amy Tyson, Office of Program Accountability, Regional Monitor (Standard 4)

Program Name: Jacksonville Youth Academy
Provider Name: TrueCore Behavioral Soluations, LLC
Location: Duval County / Circuit 4
Review Date(s): March 12-15, 2019

MQI Program Code: 1293
Contract Number: 10138
Number of Beds: 24
Lead Reviewer Code: 168

Methodology

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

Persons Interviewed

- ☒ Facility Administrator
- ☐ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- ____ # Case Managers
- **NA** # Clinical Staff
- **NA** # Food Service Personnel
- **1** # Healthcare Staff
- **1** # Maintenance Personnel
- **NA** # Program Supervisors
- **5** # Staff
- **5** # Youth
- **1** # Other (listed by title): **Lead Teacher**

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Room Restriction/Controlled Observation	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Jacksonville Youth Academy is a twenty-four bed program, for fourteen to eighteen year old males, located in Jacksonville, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides Substance Abuse Overlay Services (SAOS) where youth receive individual and group mental health and behavioral health treatment services. In addition, the program fosters each youth by providing Impact of Crime, Cannabis Youth Treatment, LifeSkills Training, and Male Healthy Relationships. Additional treatment services provided includes individual, family, and group therapy sessions, social and life skills training, victim impact awareness, recreation therapy, and restorative justice programming. Program administration is comprised of a Facility Administrator and one Assistant Facility Administrator. Case management services are provided by the director of case management and two case managers. Mental health staff at the program includes one designated mental health clinician authority (DMHCA) who also serves as the program's clinical director, and two therapists. Medical services are offered seven days a week from 7:00 a.m. to 7:00 p.m. and are provided by three full-time registered nurses (RN) to include a contract with an osteopathic physician (DO) who serves as the program's designated health authority (DHA). Educational and vocational services are provided by the Duval County School District. The layout of the program includes: one building which contains one dormitory, kitchen, cafeteria, medical unit, case management, therapists, and administrative offices, two portable buildings which serve as the education classrooms, and one portable which serves as an indoor recreation room. The program has thirty-two security cameras, twenty-one of which are operational and providing coverage. At the time of the annual compliance review, the program had five vacant positions: four youth care worker Is and one youth care worker II.

Standard 1: Management Accountability

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

The program has a written policy and procedures addressing background screenings. Nine applicable staff records were reviewed for background screenings. All nine records reviewed reflected an eligible background screening from the Association of Healthcare Administration (AHCA) Clearinghouse through the Department's Background Screening Unit (BSU). For each of the nine records reviewed, background screenings were completed prior to the date of hire, criminal histories were reviewed, and a pre-employment assessment tool was administered. All of the 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 both program and education staff and sent to the BSU on January 28, 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 written policy and procedures ensuring staff receive a background rescreening every five years from the initial date of employment. The program did not have any current staff who were eligible for a rescreening during the scope of the annual compliance review.

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

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

- *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse.*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety.*

The program has a written 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 provider are reported and handled appropriately and in a timely fashion. According to the written policy and procedures, incident reporting procedures are as follows: staff immediately notifies a shift manager, the shift manager will immediately notify the administrative duty officer to determine of the incident meets the criteria of a Central Communications Center (CCC) reportable incident; if the youth is requesting to contact the Florida Abuse Hotline, the staff member will assist the youth in placing the call immediately, and incident reports will be completed prior to the end of the staff member's shift. The program has not had any instances of physical, psychological, or emotional abuse since the last annual compliance review. Staff adhere to a code of conduct which is included in the employee handbook. Five reviewed pre-service training records reflected receipt of employee handbook, as indicated by the signature of receipt of employee handbook. Additionally, the 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. Three youth reported they have never been prevented from making a call to the Florida Abuse Hotline and two indicated they have never needed to make a call. Four of the five youth reported staff are respectful when talking with youth, one indicated some staff are respectful but bring their personal problems into work with them. Two youth reported staff use curse words often when speaking to youth, two reported staff curse occasionally, and one youth reported they have never heard staff curse when speaking to youth. Each of the five staff interviewed were familiar with the program's abuse reporting procedures. Staff reported they have never observed a coworker denying a youth the right to an abuse call, nor have they witnessed their coworkers using profanity or threatening behavior when dealing with a youth. 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 and non-reportable incidents are documented on an internal incident report form and followed up on by administration. The Facility Administrator further reported staff are required to adhere to a code of conduct and any instances of suspected abuse or neglect will result in suspension or removal from contact with youth, be investigated, and may result in disciplinary action up to and including termination.

1.04 Management Response to Allegations (Critical)	Non-Applicable
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 has not had any allegations of physical, psychological, or emotional abuse during the scope of the annual compliance review; therefore, this indicator is rated as non-applicable.

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

The program has a written 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 five incidents reported to the Central Communications Center (CCC) during the previous six months. All five incidents were reported within two hours. Documentation in the facility logbooks was found for four of the five CCC reports. A CCC report reviewed which occurred on November 29, 2018, was not observed noted in the program's logbook. The program has not 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 and non-reportable incidents are documented on an internal incident report form and followed-up on by administration.

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

The program has not had any uses of Protective Action Response (PAR) techniques during the previous two quarters and three uses of PAR techniques in the current quarter. PAR reports are kept in a dedicated PAR binder. All three PAR reports were reviewed. Each of the 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 reports. None of the reports resulted in an allegation of abuse. All three 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 three reports were reviewed by the administrator or designee within seventy-two hours of the incident. Two of three reports indicated the need for a PAR Medical Review, in which a medical review was conducted by the on-site medical staff. 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 2019 year was approved by the Department on December 20, 2018. The program's PAR rate for the previous quarter was 0.00, which is below the statewide residential rate of 1.47. According to the Facility

Administrator, all PAR reports are reviewed and compared to video surveillance of the incident. The Facility Administrator added, administration follows up accordingly and monitor trends with the monthly PAR summary.

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

The program has a written 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 written policy and procedures, staff complete a minimum of 120 hours required training within the first thirty days of employment. All five reviewed pre-service training records indicated all of the staff had well over the required 120 hours within their first thirty days of employment. Training documentation was available for review within the Department's Learning Management System (SkillPro). 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: restorative justice, trauma-informed care, and emergency procedures. One staff member completed an additional thirty-two hours specific to required training for the provider's mental health staff. All instructors are qualified to deliver training provided to staff. All pre-service training was observed 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 January 9, 2018.

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

The program has a written policy and procedures ensuring all staff maintain the necessary training to meet the needs of the program and youth in their care. Four of the 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. One staff member's training documentation reflected two hours of suicide prevention in the Department's Learning Management System (SkillPro), but not the additional four hours of required training delivered through a webinar or instructor. Additionally, this same staff member did not complete annual training on the site-specific exposure control plan. All five in-service training records reflected each staff completed over twenty-four hours of annual training. The two applicable supervisory staff completed the required eight hours training in the areas of management, leadership, personal accountability, employee relations, communication skills, and fiscal training. The program employs three registered nurses (RN), all of whom have current certifications for CPR with AED. All training, besides the exceptions for one staff member previously mentioned, were observed documented in SkillPro. The program submitted, in writing, a list of in-service training

to the Department's Office of Staff Development and Training on December 18, 2017 and the training plan and was signed on January 9, 2018. 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 written 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 expeditious manner and resolved to the best interest of the youth, the program, and the Department. The program's grievance process includes informal, formal, and appeal phases. The program utilizes "Let's Talk" forms in which youth can submit to staff at any time they may have a question or concerns. The program has had three grievances filed within the previous six months. One grievance reviewed was related to a phone call being disconnected and the other two were related to consequences as a result of disciplinary infractions. According to the written policy and procedures, the program has seventy-two hours to handle informal and formal grievances. All three grievances reviewed were responded to and or resolved the same day the grievance was submitted or within twenty-four hours. Each grievance was also 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 in the dorms, 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 of the youth reported they can ask for assistance in filling out grievances and forms are available to them. All five staff interviewed were familiar with the program's grievance procedures. According to the Facility Administrator, youth can informally handle a grievance verbally or through "Let's Talk" forms. Additionally, the Facility Administrator reported grievances may move to the formal process and if not resolved can be appealed.

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

The program provides Impact of Crime (IOC), Life Skills Training (LST), Cannabis Youth Treatment (CYT), and Male Healthy Relationships to youth in the program. All of the groups are evidence-based and provided as contractually required. The program's Clinical Director received training in Male Healthy Relationships, has a master's-level education, and over ten years of experience working with adult or juvenile offenders. The program has two master's-level therapists with a combined total of thirty years of experience working with adult or juvenile offenders. One therapist received training in CYT and Male Healthy Relationships, while the other received training in LST, IOC, CYT, and Male Healthy Relationships. The program's Case Management Director has received training in LST and IOC, has a bachelor's-level education,

and ten years of experience working with adult or juvenile offenders. The program currently has two Case Managers with a combined total of fifteen years of experience working with adult or juvenile offenders. One Case Manager has a master's-level education and is trained in LST, CYT, and IOC, while the other Case Manager has a bachelor's-level education and is trained in IOC. Education and work experience are considered by the Director of Programming when determining staff delivery of delinquency intervention services. Group sign-in sheets were available for review and found groups were delivered, as designed. A review a five youth records found all five youth have participated in CYT, IOC, and Male Healthy Relationships. All of the youth reviewed are currently participating in a LST group. The performance plans for each of the youth addressed a priority need. The program's activity schedule reflects the program is providing structured, planned programming or activities at least sixty percent of the youth's awake hours. According to the Facility Administrator, all facilitators are trained in their respective roles; Case Managers are used for IOC and LST, while therapists are utilized for CYT. Additionally, the Facility Administrator reported the program provides LST, CYT, IOC, and Male Healthy Relationships. Further, LST and IOC groups are held twice a week in the evenings.

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

A review of the program's contract reflected the program provides Life Skills Training (LST) to youth in the program. Youth in the program receive life skills intervention services specifically addressing communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking, to include problem-solving and decision-making. A review of the program's activity schedule reflected LST is conducted twice a week. Each of the five reviewed youth records reflected all of the youth are currently participating in LST. Group sign-in sheets were available for review and found groups are delivered, as designed. Five of five youth interviewed were able to report the current groups they are participating in and new skills or behaviors they have learned. The Facility Administrator reported LST is conducted twice a week.

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 contractual agreement found the program provides the Impact of Crime (IOC) curriculum to enhance restorative justice awareness for youth. A review of group sign-in sheets revealed the program conducted groups, as required. Five youth records were reviewed and found each youth were receiving, or have received, the IOC curriculum to increase their accountability for criminal actions and harm to others. The program's restorative justice activities are designed to teach youth about the impact their crime had on victims, expose youth to the victims' perspectives through victim impact statements, and provide opportunities for youth to plan and participate in reparation activities intended to restore victims and communities, such as restitution activities and community service projects. Program youth most recently visited the Straight and Narrow program, for local at-risk youth, to speak on the impacts of their crimes to local at-risk youth. Additionally, the youth visited the Five Star

Veteran's program and served food to local veterans. A review of four staff training records for staff facilitating the IOC curriculum found evidence each received certifications in delivering the curriculum. A review of the program's activity schedule determined restorative justice groups are provided, as required. All five interviewed youth reported they have participated in IOC. The Facility Administrator was interviewed and stated IOC groups are held two times a week in the evenings. In addition, the youth participate in Alcoholics Anonymous and Narcotics Anonymous groups every other Saturday morning.

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

A review of the provider's contractual agreement found the program is providing Male Healthy Relationships curriculum, which is a bundled service of Teen Relationships and Young Men's Work. A review of the curriculum, group materials, and youth sign-in sheets confirmed the program provided the services, as required. The program designed its services based on the common characteristics of its male population, to include youth ages and service needs. A review of the program's activity schedule found provisions for gender-specific programming. The Facility Administrator was interviewed concerning gender-specific programming and stated Male Healthy Relationships group and the selections of grooming, hygiene, clothing, and recreational offerings are the ways the program addresses the needs of the male youth population.

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

The program has a written policy and procedures 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 inputting of alerts within the Department's Juvenile Justice Information System (JJIS). All five youth records had evidence alerts were entered into JJIS, as required. All alerts were verified prior to their entering into JJIS. One of five alerts reviewed, which was entered November 1, 2018, was for a suicide risk. The youth was taken off suicide risk two days later; however, the alert was not closed until March 11, 2019. The remaining alerts reviewed had no discrepancies. Three 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 were found to be consistent with alerts entered within JJIS. Discussions were held with annual compliance review team members reviewing areas of safety and security, mental health, case management, and medical found no issues with youth alerts for these areas reviewed. All alerts requiring removal or downgrading were found to have been done so by the appropriate staff member required. The Facility Administrator was interviewed concerning the program's internal alert process, as well as the

process of inputting alert information into JJIS. The Facility Administrator stated all alerts are generated based on identified risks or needs determined at admission or during treatment. They are reflected on internal alert postings and in JJIS. Alerts are reviewed in the morning management meetings, the program's internal alert board, and within the logbook. Mental health alerts are handled by clinical staff, medical alerts are done so through medical staff, and the security alerts are inputted by case management. Five interviewed staff reported they are briefed on youth alerts through discussion with shift supervisors, shift briefings, the internal alert board located in master control, and during shift changes.

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 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 file tab 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 constructive input from youth. A review of sign-in sheets and agendas found evidence the program hosts House Meetings and Youth Advisory Board Meetings five to ten times monthly. The program also provides Let's Talk forms for youth. 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 random surveys for ten youth quarterly. The Facility Administrator was interviewed concerning the program's efforts to provide youth the opportunity to give input and revealed this is done through the use of youth surveys, listening sessions, and the Youth Advisory Board. In addition, the Facility Administrator stated youth representation has been added to the Community Advisory Board meetings. Five youth were interviewed concerning their ability to provide input into programming operations. One youth state he just stays to himself. Two youth reported they can speak with staff if they need to. One youth reported he is able to speak with the Facility Administrator if he has any feedback to give. The remaining youth reported input is given through the Youth Advisory Board, which also gives opportunity to speak with fellow peers and discuss with them what may be needed, but within reason.

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

The program holds Community Advisory Board meetings on a quarterly basis. A review of meeting minutes and sign-in sheets found evidence the program held meetings for three of the previous four quarters. The program was missing a meeting for the second quarter of the annual compliance review period reviewed. Based on documentation reviewed, the Facility Administrator solicits active involvement from a member of law enforcement, the judiciary, community partners, local business community, the school board district in the area, and faith community. In addition, the Facility Administrator recruited victim advocacy participation and a parent/guardian whose child was previously involved in the juvenile justice system. A majority of the members participated consistently. A telephonic interview with an advisory board member was performed during the annual compliance review. The member confirmed their participation in group meetings and stated they meet quarterly to plan and discuss program activities. The individual reported they have been a member since 2014. The Facility Administrator was also interviewed concerning the program's Community Advisory Board. He reported they meet quarterly to help the community positively impact the program and the program positively impact the community. He informed they have members from judicial, law enforcement, education, business, faith-based, victim services, and parents/guardians of past youth. The Community Advisory Board asks what items or services can be provided to the youth and suggests activities to enrich the youth or to allow them to serve the community.

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 parent/guardians surveys to complete to utilize data for program planning. The survey results are incorporated into the planning process through sharing of information in All Staff Meetings. This information was verified through a review of meeting minutes. The Facility Administrator ensures provisions for staffing by using 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. The program also has a written policy and procedures to determine the system of staff communication, opportunities for providing input, and feedback on the program's operations. The program hosts Shift Briefing Meetings and Management Meetings daily. All Staff Meetings are done monthly. Five interviewed staff reported staff meetings were held monthly. One of the five staff reported they were held daily and monthly. The five interviewed staff reported topics of meetings included things such as issues with youth, job responsibilities, incentive opportunities, program events, youth alerts, and team building. All five staff reported they were briefed on Commission on Accreditation of Rehabilitation (CAR) information. The Facility Administrator reported the information in the CAR report was last discussed in the January All Staff Meeting held. Three of five staff reported the communication at the program was good. One staff reported it was fair, and one staff reported it was very good. An interview with the Facility Administrator revealed the following meetings for staff were held: Morning Management Meetings, All Staff meetings, Department Meetings, and Community Meetings. The Facility Administrator further reported they were new to the position but have worked to fill vacancies and build morale. The program has a bonus system and rewards program, Employee of the Month, and Employee of the year. The Facility Administrator was questioned regarding outcome data used by the facility, and how

the information was used for program planning. The Facility Administrator responded stating parent/guardian surveys, youth surveys, internal audits, and external audits are used to identify strengths and needs for improvement. In addition, the Facility Administrator reported being on-site during visitation days and can solicit information from parents/guardians.

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

The program has a written policy and procedures for evaluating staff, performance standards, and detailing 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 of position descriptions was conducted and determined each staff member's performance standards were clearly identified. A sample of performance evaluations were also reviewed and determined to be completed consistent 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 they evaluate each staff on roughly twenty areas specific to their role, and goals are established for the staff each year. Five staff were interviewed and asked how often they receive performance evaluations. One staff reported yearly, two staff reported every six months, three staff reported they were newer staff and have yet to receive an evaluation.

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.	

Five case management records were reviewed, and all five records indicated the program notified the youth's parent/guardian by telephone within the twenty-four hours of admission. The program also notified the parent/guardian in writing within forty-eight hours of admission. Four of the five records included documentation to support the committing courts, juvenile probation officers, and post-residential counselors were notified within five working days of the youth's admission to the program. One record did not include documentation to support the committing court was notified within five working days of the youth's admission.

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

Five case management records were reviewed, and all five records indicated the program provides each youth with a program orientation within twenty-four hours of admission. Orientation included all required elements such as services available, expectations, responsibilities, access to medical services, access to the Florida Abuse Hotline and access to mental health services. Five youth were interviewed, and all responded they received orientation within twenty-four hours of admission into the program. Additionally, each youth was able to explain the orientation process.

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

Three of the five records were applicable for youth eighteen years or older were reviewed. Documentation for each record indicated the program had documented consent before discussing physical or mental health screenings, assessments, and treatment with the youth's parent/guardian.

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

Five case management records were reviewed, and each record indicated the program had documentation reflecting youth are initially classified on the date of admission. The program has a system in place used for the purpose of classifying a youth based on the youth's physical characteristics, maturity level, and gang affiliation, suicide risk factors, including medical, mental health, substance abuse, and security risks, as well as special needs in order to assign a youth to living area and sleeping room. All youth identified with risk factors were entered into the Department's Juvenile Justice Information System (JJIS). The youth risk assessment binder was reviewed and there was documentation indicating youth were reassessed monthly for an increase in youth's privileges or freedom of movement, participation in work projects, and/or off-campus activities. According to the Facility Administrator, youth receive a risk assessment upon admission to ensure they are placed in the safest manner possible by considering age, stature, maturity, aggression, mental health, and gang factors.

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.	

Two of five case management records were applicable for suspected gang involvement. One additional record applicable for gang identification was reviewed. All youth entering the program are screened for gang involvement and affiliation. The local law enforcement is notified, as well as the Juvenile Probation Officer (JPO) and law enforcement from home county where the youth resides. The program notified local law enforcement and in the youth's home county in two of the three case management records reviewed. It was noted during the review there was no documentation of notifications of one case record to local law enforcement. Upon acknowledgement, the program sent notification to the local law enforcement agency.

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.	

Two of the five case management records were applicable for suspected gang involvement. Each youth's individual performance plan included gang prevention goals and each youth participated in gang prevention and intervention strategies. The program maintains a gang notebook which includes gang awareness and prevention training for the youth. The program

also completes a monthly gang sharing information form which identifies newly identified youth, gang-related behavior and contraband, and is shared with all program staff.

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

Five case management records were reviewed for Residential Positive Achievement Change Tool (R-PACT) Assessments and Reassessments. Each record revealed the youth had an initial R-PACT assessment completed within thirty days of admission. Of the five case management records, the program conducted reassessments for three of the youth within ninety days after completion of the initial R-PACT. Two case management records were not completed within the ninety-day timeframe and were eleven days late. Initial assessments were entered into the Department's Juvenile Justice Information System (JJIS).

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

Five case management records were reviewed. Each record contained documentation the youth had a Youth Needs Assessment Summary (YNAS) completed within thirty days of admission, which was also maintained 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.*	

Five case management records were reviewed for performance plan goals based on the findings of the initial assessment of the youth within thirty days of admission. Each youth's Treatment Team was present during the development of the Individual Performance Plan, as indicated by their signatures. All five records indicated criteria were met in the performance plan goals including specific delinquency interventions and measurable outcomes to decrease risk

factors/increase protective factors. There were individualized goals based upon the prioritized needs reflecting risk and protective factors identified during the initial assessment process. The performance plans also included court-ordered sanctions which could be initiated/completed while the youth were in the program. Transition activities were targeted for the last sixty days of the youth's stay. The youth and program were responsible to accomplish goals and there were target dates for completion. All five records reviewed had documentation supporting the program included the youth's noted gang involvement in the performance plan. Each of the five youth interviewed could explain the treatment team process and describe goals they are working towards. Additionally, all of the youth reported they received a copy of their performance plans.

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.	

Five case management records were reviewed, with three of them reflecting revisions to youth's performance plan when determined necessary by the intervention and treatment plan. Each of the youth had revisions to their performance plans due to Residential Positive Achievement Change Tool Reassessment results, newly acquired information, and progress towards completing goals. For the three applicable youth reviewed, performance plans reflected transition activities for the last sixty days of the youth's stay.

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

A review of five case management records found the performance summaries at ninety-day intervals, beginning ninety days from the signing of the youth's performance pan, or at shorter intervals when requested by the committing court, were completed. Performance summaries were also completed for youth during discharge. All summaries included the youth's status on each performance plan goal, treatment process, academic status, behaviors, levels of motivation or readiness to change, interactions with peers and staff, overall behavior adjustment to the program, and significant positive and negative changes. Transmittals were sent to the parent/guardian, committing court, and juvenile probation officer (JPO). All original summaries were found in the youth records and were signed by all parties. Copies of the performance summaries were sent to youth's JPO, committing judge, and parent/guardian within ten days of completion of the summary. Each of the three closed records showed a copy of the summary was maintained in the record and the original was sent to the JPO with the Pre-Release Notification (PRN). Five youth were interviewed, and four of five youth responded they have received a copy of their performance summary.

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.	

Five case management records were reviewed. In all five of the records, the parent/guardian was involved in the case management/assessment process, invited to participate in the development of the performance plan, and were given progress reviews regularly. The youth's parent/guardian was contacted, by phone, and the signature page of the performance plan was returned with the parent's/guardian's signature. There were letters to youth's parent/guardian informing them of formal treatment team meetings for the youth. The letters included the date and time of the formal treatment team meetings. Two treatment team meetings were observed during the annual compliance review week to confirm the youth's parent/guardian participation and both treatment teams were conducted as required. Five of five interviewed youth reported their parent/guardian has been involved in their treatment team meetings. According to the Facility Administrator, parents/guardians are encouraged to participated in the treatment team process through phone calls and written correspondence.

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.	

Five case management records were reviewed, and each youth record documented treatment team member's signatures or phone participation. Treatment team members included a treatment team leader, the youth, an administration staff, a living unit representative, treatment staff, educational staff, juvenile probation officer (JPO), and parent/guardian. There is also written input from living unit representatives, as well as from education and medical staff. Reviewed documentation indicated all required members of the treatment teams were actively participating in the process.

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

Five case management records found each individualized performance plan referenced the youth's academic and treatment plan. Academic, treatment plans, and case plans through the Department of Children and Families are incorporated into the individualized performance plans when applicable. One of the five youth records reviewed were involved with an outside agency in which his case plan was observed to be incorporated into his performance plan.

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

Five case management records were reviewed for treatment team reviews. All five youth were applicable for formal and informal treatment team reviews. Formal reviews were completed at least every thirty days and documented the youth's name, date of review, attendees, and written comments from the treatment team, youth progress, revisions, positive and negative behaviors, and any physical interventions. Informal reviews were conducted at least bi-weekly and included youth's name, date of review, attendees, comments from the treatment team members, youth progress, and any revisions. The reviews also included any progress made, positive and negative behaviors, any physical interventions, and any Residential Positive Achievement Change Tool (R-PACT) Reassessment results. Five youth were interviewed and three responded they get the opportunity during treatment team meeting to demonstrate skills they have learned at the program.

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

A review of three closed records found each record included a completed employment application, appropriate documents essential to obtaining employment, and documentation reflecting the youth's parents/guardians and juvenile probation officer (JPO) were aware of the vocational plan for the youth. All of the records contained a resume and evidence of an appointment with the Career Source Center in the area the youth will be residing. The program provides appropriate career education based on age, length of stay, and is appropriate for the educational abilities of the youth in the program. The program provides Type II vocational competency development which includes Type I program content. Programming includes communication, interpersonal skills, and decision-making skills. According to the Facility Administrator, youth are offered employment readiness, food handling, first aid, cardiopulmonary resuscitation (CPR), and Occupational Safety and Health Administration (OSHA) training. The lead teacher confirmed the program is a Type II vocational program in which youth participate in job skills training.

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

The Duval County School District provides education based on a 250-day calendar, with bell schedule beginning at 7:45 a.m. until 2:30 p.m., with a structure of four, one hour and fifteen minute classes. The youth receive credits for the education and training received while at the program. An interview with lead teacher revealed the youth are regularly late to class. The lead teacher further reported teachers are, at times, tardy; however, the program staff regularly do not bring the youth to class on time. A review of the log books over four months, with six days chosen at random, reflected youth arriving anywhere between fourteen to thirty-two minutes late each day. One of the six days reflected documentation of youth being released from school, in this case youth were released thirty minutes early. These observations indicated youth are not receiving the required twenty-five hours of instruction each week. Two of five youth interviewed reported class is regularly interrupted, while three reported no interruptions.

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

Three closed records were reviewed for educational transition plans. Each record had an individual education transition plan developed based on youth's post-release goals beginning at admission to include all key personnel related to transition activities, and included responsibility requirements, and post release needs. Three closed records were reviewed for employability as a transition goal and included provisions for continuation of education and/or employment, appropriate documents essential to obtaining employment, evidence of an appointment with the Career Source Center within the area the youth will be residing, sample employment application, resume, and documentation the youth's case manager and parents/guardians were aware of the plan.

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

A review of five youth case management records found all of the youth had transition planning including transition conferences, which were held at least sixty days prior to the youth's targeted release date. Documentation confirmed the youth, treatment team leader, Facility Administrator or designee, parent/guardian, and any other pertinent treatment team members were present during the conferences. In addition, transitional planning was developed with the youth, education, program, and aftercare staff. All three youth records reflected evidence the youth and case managers participated in a Community Re-entry Team (CRT) meeting held prior to the youth's release.

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

A review of three closed case management records found all records contained an exit portfolio. Each portfolio contained a copy of the youth's identification card, social security card, birth certificate, transition plan, and calendar containing follow-up appointments. The portfolio also included completed sample job applications, resumes, vocational certificates, educational records, and school transcripts. Each youth record included the Electronic Educational Exit Plans (EEEPs) and/or referrals including educational recommendations. The program utilizes a form in which the youth and parent/guardian signs stating they received their portfolio upon release.

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

Three closed case management records were reviewed for an exit conference. In each of the three records, documentation reflected the exit conference was conducted after the juvenile probation officer (JPO) was notified of the youth's release. All of the records reflected the exit conference was conducted at least fourteen days prior to the youth's release. A summary was found in all three records and included the date, signatures, names of participants by phone, and a summary of pending transition goals. Documentation reflected the date of admission and

date of termination documented in the case management records correlate with the Department's Juvenile Justice Information System (JJIS). The following participated in the exit conferences for each youth: treatment team leader, parent/guardian, education representative, JPO, and youth. Exit conferences were held separately from transition meetings for each youth.

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory Compliance
Each Facility Administrator 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 written policy and procedures outlining the role of the director of clinical services who is the program's Designated Mental Health Clinician Authority (DMHCA). The program's DMHCA is a licensed mental health professional under Chapter 491. The DMHCA is on-site forty hours a week (Monday-Friday) and on-call for all mental health emergencies. The DMHCA's schedule reflects sufficient time to ensure appropriate coordination and implementation of mental health and substance abuse services is taking place. The DMHCA also provides clinical supervision to the program therapists in a face to face setting on a weekly basis, review and sign off on comprehensive assessments, Assessments of Suicide Risk, initial treatment plans, individualized treatment plans and treatment plan reviews, and review and sign-off on all non-licensed therapists work. A review of the DMHCA's licensure reflected a clear and active licensed mental health counselor (LMHC) in the State of Florida as verified on the Florida Department of Health website. The current license expires March 31, 2021**.**

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Satisfactory Compliance
The Facility Administrator 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 for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. The program's clinical staff is in accordance with the contract and Rule 63N-1, F.A.C. The program has one licensed mental health counselor, one licensed marriage and family therapist, and a certified addiction professional pursuant to Chapter 491, F.S. The Designated Mental Health Clinical Authority (DMHCA) ensures all clinical staff members working under their supervision are performing services the staff members are qualified to provide based on the staff's education, training, and experience.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory Compliance
The Facility Administrator 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 one non-licensed counselor working under their supervision of the licensed mental health counselor. The non-licensed counselor has a master's degree from an accredited university in special education. The non-licensed counselor receives one hour each week of on-site face-to-face direct supervision. The direct supervision is recorded on the provider's form with similar form which includes all information of the MHSA 019 form. The non-licensed mental health clinical staff completed twenty-four hours training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The program has a master's-level addiction professional.

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

The program has a policy and procedures for conducting admission screenings. Five youth records were reviewed. The program's facility operation procedures (FOP) states all youth will be administered an Assessment of Suicide Risk (ASR) within twenty-four hours of the youth's admission to the program. All five records had an ASR. Two of the five reviewed records required further referrals. The two youth were referred for further evaluations as required by the FOP. The Facility Administrator's interview indicated knowledge of the requirements for youth at risk for mental health and/or substance abuse problems and suicide. Each youth record also contained a completed MAYSI-2.

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 for assessing and evaluating youth for mental health and substance abuse services. The program policy requires a comprehensive mental health and substance abuse evaluation be completed on all youth admitted to the program. A review of five records indicated each of the five youth had a new comprehensive mental health evaluation completed within thirty days of admission. Four of the five comprehensive mental health evaluations were completed by a non-licensed mental health clinical staff. The four comprehensive mental health evaluations were reviewed and signed by a licensed mental health professional within ten calendar days of the evaluation being completed. Each of the five new comprehensive mental health evaluations contained the following: identifying information, reason for evaluation, relevant background information, behavioral observation, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression which included a Diagnostic Statistical Manual (DSM) diagnosis, and recommendations.

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

The program has a policy and procedures for providing youth mental health and substance abuse treatment. Five youth records were reviewed for mental health and substance abuse treatment. Each of the five youth records had documentation indicating each of the youth were assigned to a treatment team upon admission to the program. The program's multidisciplinary treatment team is comprised of the youth, program administration, staff from the residential living unit, and other staff responsible for the delinquency intervention and treatment for the youth. Five youth records were reviewed for mental health and substance abuse treatment services. Each record contained documentation to validate the treatment team was comprised of representatives from administration, education, medical, and mental health staff. The youth's parents/guardians were invited to participate in the development and review/update of the youth's treatment needs. The program sends letters to parents/guardians listing dates and times of all treatment team meetings.

Each of the five youth records reviewed had substance abuse treatment needs. All five records contained documentation showing each youth was receiving individual and group counseling, and family therapy interventions. Substance abuse services are provided by the program in accordance with Chapter 397, Florida Statues to provide substance abuse services; certified by the Department of Children and Families, which expires April 7, 2019. Each of the five youth had a valid Authority for Evaluation and Treatment (AET) form completed. Each of the five youth had a signed substance abuse consent and release forms found in their records. All five youth records contained necessary mental health and substance abuse treatment notes, documented on a form which contained all the information in form MHSA 018. Five youth records were reviewed for mental health and substance abuse group therapy.

A review of youth sign-in sheets for mental health treatment groups documented, group size was limited to ten or fewer youth. A review of youth sign-in sheets for substance abuse treatment groups documented, group size was limited to fifteen or fewer youth. Each of the five youth were receiving individual psychotherapy or counseling (one-to-one) as prescribed within their individual treatment plans. All five youth were receiving psychosocial skills training specifically addressing symptoms or maladaptive behaviors addressed within their individual treatment plan. Five staff were interviewed. The five direct care staff members indicated all groups are conducted by mental health and substance abuse treatment clinical staff. An informal interview with the Designated Mental Health Clinician Authority (DMHCA) regarding the treatment services at the program indicated knowledge of the treatment process and services.

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

The program has a policy and procedures for treating and discharging youth. A review of five active records for treatment planning confirmed each record had an initial mental health and substance abuse treatment plan. All five of the initial mental health and substance abuse treatment plans which included all elements of Department form MHSA 015. Four of the five youth were on psychotropic medications. Three of the four were on psychotropic medications upon admission; one youth was prescribed after admission to the program. The five records had initial mental health and substance abuse treatment plans developed within seven days of the initial psychiatric diagnostic interview. Four of the five initial treatment plans were completed by a non-licensed mental health clinical staff. The four initial treatment plans were reviewed and signed by a licensed clinical supervisor within ten days of completion. The remaining one initial treatment plan was completed by a licensed mental health counselor (LMHC). All five initial treatment plans were signed by all treatment team members who participated in the development of the plan. Four of the five youth records required psychiatric services including the youth's psychiatric needs, which included medication and frequency of monitoring by the psychiatrist. All five of the youth records contained initial treatment notes, which included all information required from Department form MHSA 015.

Five youth records were reviewed for individualized treatment plans and reviews. Each of the five youth records contained an individualized treatment plan, which was developed within thirty days of the youth admission to the program. Each of the individualized treatment plans were developed on a form, which contained all the elements of Department form MHSA 016. Four of the five youth individualized treatment plans were completed by a non-licensed mental health staff. The four plans were reviewed and signed by the licensed supervisor within ten days of completion. The remaining individualized treatment plan was completed by a LMHC. Each of the five individualized treatment plans were signed by treatment team members, and the youth, and parent/guardian, when available. Four of the five individualized treatment plans required psychiatric services, to include psychotropic medication and frequency monitoring by the psychiatrist. A total of twenty-two individualized treatment plan reviews were conducted. Each of the reviews were completed on a site-specific form, which contained all the information from Department form MHSA 017. Each of the individualized treatment plans documented the on-going prescribed services; individual, group, family, and/or psychiatric services, as required.

Three closed youth records were reviewed for discharge plans. Each of the three discharge plans were documented on Department form MHSA 011. None of the three youth records reviewed required any type of notification for suicide risk/precautions. All three mental health and substance treatment discharge summaries contained services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by youth during treatment. The three discharge plans contained documentation of discussion with the

youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. A copy of the mental health and substance abuse treatment discharge summary was provided to the youth, JPO, and parent/guardian.

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

The program provides Substance Abuse Overlay Services (SAOS) for all youth entering the facility. The services include drug screening, urinalysis drug testing, individual, group, and family therapy; daily therapeutic activities such as substance abuse education, relapse prevention, substance refusal skills, and coping skills. The program is licensed in accordance with Chapter 397, Florida Statues to provide substance abuse services; certified by the Department of Children and Families, which expires April 7, 2019. A qualified substance abuse professional staff is on-site at least five days a week. Each counselor has a caseload no more than twelve youth for SAOS treatment services. An interview with the facility administrator indicated knowledge of the program's contractual specialized treatment services.

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

The program has a contract with a psychiatrist, who has completed psychiatry, pediatrics, and child/adolescent psychiatry certification by the American Board of Psychiatry and Neurology. The psychiatrist's license is clear and active; which was verified through the Florida Department of Health, division of quality assurance and good through January 31, 2020. Three of the five reviewed youth records indicated the youth entered the program on psychotropic medications. One of the remaining youth was prescribed psychotropic medications after admission to the program. One youth did not require psychiatric services. All of the applicable youth were provided with an initial diagnostic interview with fourteen days. The initial diagnostic psychiatric interview included the youth's history (medical, mental health, and substance abuse), mental status examination, a diagnosis from the diagnostic statistical manual (DSM), treatment recommendations, prescribed medications (when applicable), explanation of the need for psychotropic medication, and frequency of medication monitoring. The initial diagnostic psychiatric interview was documented on the Department's form entitled Clinical Psychotropic Progress Note (CPPN) and was clearly identified as an "initial diagnostic psychiatric interview." In all three records, although no changes to either youth's psychotropic medication regimen occurred, the psychiatrist still utilized page three of the CPPN to document the psychiatric interview findings and recommendations. The youth entering, and the one youth prescribed after admission received a psychiatric evaluation within thirty days of admission to the program. All the youth received a psychotropic medication review by the psychiatrist every thirty days. Each of the psychiatrist psychotropic medications reviews were documented on the CPPN. One youth was in foster care prior to entering the program; however, at intake, the youth was eighteen years old. A review of sign-in/out logs confirmed visits by the psychiatrist every two-weeks.

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

The program has a policy and procedures to include a written suicide prevention plan, which was reviewed by the designated mental health clinician authority (DMHCA) on September 11, 2018 and signed by the facility administrator on January 14, 2019. According to policy, an Assessment of Suicide Risk (ASR) is to be completed for each youth during the intake process. The procedures outline the identification and assessment process, suicide precautions, the levels of supervision to include one-to-one supervision, constant supervision, and close supervision; immediate staff response, and staff supervision requirements during the use of precautionary observation. The policy details the referral, communication, notification, and documentation process. The plan also outlines the process for serious suicide attempts or serious self-inflicted injury, and a mortality review. The requirement of six hours of annual in-service suicide prevention training for staff was cited in the program's policy, as well as, the pre-service training, lectures, and practical applications to address suicide precautions, levels of supervision, crisis response, documentation, signs, and symptoms.

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 an established review process for a serious suicide attempt or serious self-inflicted injury, and a mortality review for a completed suicide. The review process is outlined in the program's suicide prevention plan. The review process includes the circumstances surrounding the event, procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

Five youth records were reviewed for suicide prevention services. Only one of the original five records required additional services; therefore, two additional youth were reviewed for suicide prevention services. The program's policy and procedures require an Assessment of Suicide Risk (ASR) to be completed, utilizing the Department's form (MHSA 004) for each youth upon admission. Three youth were reviewed for suicide prevention services. The intake staff reviewed the youth's commitment packet information, reports and records, and administration of the Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2). The three youth were placed on suicide precautions and documented, as required, in the Department's Juvenile Justice Information System (JJIS) alert. Non-licensed clinical staff completed an ASR for each youth at admission, meeting the twenty-four-hour requirement of screening or concerns. Each of

the ASRs were reviewed by a licensed staff within the required timeframe. Two of the three youth were placed on suicide precautions, and notifications from the shift supervisor were completed. Two of the three youth required a follow-up ASR. One youth was admitted to the program from a detention center on suicide precautions and was stepped down to standard supervision after the program completed an ASR.

Five staff members were interviewed. The staff interviews indicated if a youth expresses suicidal thoughts, direct care staff are responsible for notifying mental health staff, searching the youth and room for sharp objects, maintaining constant sight and sound of the youth, and documenting supervision.

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

The program has a policy and procedures for youth placed on precautionary observation (PO). The program utilizes the Department's form (MHSA 006) to document a youth placed on precautionary observation. Five youth records were reviewed for implementation of suicide precaution observation logs. One of the five youth required the use of a precautionary observation log; therefore, two additional youth records were reviewed. The appropriate level of supervision and observations of the youth's behavior were documented in real time and did not exceed thirty-minute intervals. Warning signs were observed and documented on the suicide precaution observation log. The logs were reviewed and signed by the shift supervisor and mental health clinical staff. Each log reviewed had documentation for safe housing requirements. Three youth placed on precautionary observations were asked if staff remained with them at all times while on precautionary observation. All the youth answered "yes."

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

The program has a policy and procedures requiring staff to complete suicide prevention training. A total of five staff records were reviewed for suicide prevention training. Four of the five staff completed six hours of annual training, as required. The remaining staff did not have all the required six hours; only completing two of the six hours required. The program conducted nine mock suicide drills (October 17- 18, 2018, January 25 and 29, 2019, and March 4, 2019), covering three separate shifts during the annual compliance review period. Each of the mock suicide drills contained, at a minimum, a method for contacting other program staff by radio or for back-up support, to include contacting emergency medical services (9-1-1). In addition, each mock suicide drill included life saving measures such as cardiopulmonary resuscitation (CPR), and/or the use of the suicide response kit. Each of the drills had thorough documentation and included photos of the events during the drill.

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

The program has a written crisis intervention plan which is maintained separately from the emergency mental health and substance abuse services plan. The crisis intervention plan details the response to youth in crisis in the least restrictive method possible, and to protect the personal safety of the youth and others while maintaining control and safety of the program. The policy was reviewed by the Designated Mental Health Clinician Authority (DMHCA) on September 11, 2018 and signed by the Facility Administrator on January 14, 2019. The plan details the notification and alert system, the referral process to include a youth's self-referral, communication, supervision levels and requirements, documentation, and a review process.

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

The program has a policy and procedures for crisis assessments. The program did not have any youth requiring a crisis assessment during the annual compliance review period. The crisis intervention plan addresses the practices needed for effectively handling youth in need of a mental status exam and crisis assessment. The program utilizes Department form MHSA 023, "Crisis Assessment," and a mental status exam to document reason for conducting an assessment. The crisis assessment included the reason for assessment, mental status examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision, treatment, and follow-up evaluation recommendations.

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

The program has a written emergency mental health and substance abuse plan which was signed by the Designated Mental Health Clinician Authority (DMHCA) on September 11, 2018 and by the Facility Administrator on January 14, 2019. The plan outlines the immediate staff response, notifications, communication, supervision, and authorization to transport for

emergency mental health and substance abuse services. The plan includes the procedures of transportation for emergency mental health and treatment for a Baker Act, and transportation for emergency substance abuse assessment and treatment under a Marchman Act. The policy and procedures include the documentation, training and review process. The policy identifies the location for a Baker Act as the Mental Health Resource Center (MHRC-North, Jacksonville, Florida). The Marchman Act for substance abuse services is located at Gateway Community Services in Jacksonville, Florida.

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

The program did not utilize a Baker Act or Marchman Act procedures during this annual compliance review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

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

The Designated Health Authority (DHA) is a licensed osteopathic physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. A review of documentation for the past six months was reviewed and reflected the DHA is on-site once a week. There is coverage arranged with another doctor in the event the DHA is on vacation or another scheduled absence. The DHA was interviewed and confirmed he is on-site at least two hours every week. He further described his role to include performing Comprehensive Physical Assessments upon youth admission and then annually thereafter, conducting periodic evaluations every sixty days on youth with chronic conditions or youth prescribed medications, and addressing sick calls that have been referred to the DHA. The DHA is available by phone twenty-four hours a day, seven days a week.

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

The program's health-related policies, procedures, and protocols were reviewed, and they properly outlined the program's healthcare services. The policies, procedures, and treatment protocols were reviewed and signed by the Designated Health Authority (DHA). The DHA and Facility Administrator signed and dated all respective treatment protocols. A cover page listing all facility operating procedures was signed by administration and medical staff.

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.	

Five records were reviewed. Four records contained an Authority for Evaluation and Treatment (AET) stamped with the word "copy." The AETs are valid until the youth's eighteenth birthday. Two youth turned eighteen after they were admitted to the program and a form for release of information was completed for both youth. One youth arrived at the program after his eighteenth birthday and a release of information authorization form for youth eighteen and over was completed. Copies of completed parental notifications were maintained behind the AET in all five records.

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

Five records were reviewed. All of the records contained documentation of parental notification for over-the-counter medications beyond those covered by the Authority for Evaluation and Treatment (AET). Additionally, notifications were sent, as needed, for issues such as the discontinuation of medication prescribed prior to youth entering custody, changes in

condition/medication for youth with chronic conditions, non-routine dental procedures, and for new medications. Nursing staff stated the parent/guardian is called in addition to sending out a written consent to be signed and returned. Documentation of the verbal contact, along with a witness, is noted on the chronological nurses notes and the copy of the mailed consent is kept in the youth's medical record. The nurse further stated verbal and written notifications are made when giving a medication that is not listed on the AET, during significant medication changes, and when going off-site for an appointment or during an emergency.

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

Four youth records were applicable for psychotropic medications. In all four records, notification was mailed, along with the Clinical Psychotropic Progress Note (CPPN) (pg. 3) and explanatory information for the initiation, changes, or discontinuation of psychotropic medication. One youth was eighteen years old at the time of admission; therefore, verbal consent from the parent/guardian was not required. One youth's record reflected verbal consent was obtained for the CPPN and documentation reflected a staff member witnessed all telephone call attempts and conversations, and the parent/guardian returned signed forms. One record reflected telephone contact with the parent/guardian was made and the parent/guardian did not consent to the medication and requested to speak to the doctor. One record reflected verbal consent from the parent/guardian, and the notification was mailed, but not returned with the parent's/guardian's signature.

The nurse explained the process as follows: verbal consent from the guardian is obtained by the psychiatrist and witnessed by the register nurse (RN) for any medication initiations, discontinuances, or if changed outside of previously set medication range. The RN signs as a witness on the CPPN if verbal parental contact is made. Parental notifications and CPPNs are sent by certified mail if any medication initiations, discontinuances, or are modified outside of the previously set medication range.

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

Five records were reviewed which reflected vaccinations were verified within thirty days of the youth's admission. All youth had the required immunizations, and none refused consent for immunizations. The nurse explained if a parent/guardian claims exemption and does not consent to vaccinations for religious reasons, the parent/guardian must file a waiver with the health department. The DHA can override this, if it is deemed medically necessary.

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

Five records were reviewed and all five contained a Facility Entry Physical Health Screening (FEPHS) form completed on the date of each youth's admission. In each of the five reviewed records, the FEPHS form was completed by a registered nurse.

The nurse stated youth are seen in medical upon their arrival. The FEPHS form is completed by the nurse and only completed by non-nursing staff if the youth arrives after hours or there is no nursing staff on-site. In the case that non-healthcare staff complete the FEPHS form, nursing staff will review the FEPHS within twenty-four hours.

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

The program has a medical alert system in place. The alerts included youth with a chronic condition, youth medical grades, and conditions warranting placement on medical alert. The medical alert system is reviewed and updated daily and as needed by the nursing staff. All applicable medical alerts were accurate and reflected in the Department's Juvenile Justice Information System, as well as the program's internal alert system.

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

Five records were reviewed and reflected each youth received a healthcare orientation on the day they were admitted to the program. The healthcare topics included the following: access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process to include side effect monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care providers.

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

Five records were reviewed and, in each record, the Designated Health Authority (DHA) was notified by telephone of the youth's admission. None of the youth were identified as in-need of an emergency response. The nurse was interviewed and 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.

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

Two of the five reviewed records were applicable for healthcare admission rescreenings; therefore, an additional record was reviewed. In all three applicable youth records reviewed, the program completed a new Facility Entry Physical Health Screening (FEPHS) form upon the youth's return to the program. In two records, the form was completed by a registered nurse, and in the remaining record, it was completed by direct care staff and subsequently reviewed by a registered nurse within twenty-four hours.

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

Five records were reviewed, and each contained documentation reflecting the Health Related History (HRH) was completed on the day the youth was admitted to the program. All five were new forms which were completed by a licensed nurse. In each record, documentation supported the HRH was completed prior to the Comprehensive Physical Assessment and the physician reviewed the HRH.

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

Five records were reviewed for completion of the Comprehensive Physical Assessment (CPA). The program uses the Department's CPA form. In each record, the CPA was completed within seven calendar days of admission. All five were completed by the physician. The CPA was filled out in its entirety. No section was marked as deferred by the youth.

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

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

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

The program has a policy and procedures for tuberculosis (TB) screening. Five youth records were reviewed and confirmed all youth had a verified tuberculosis skin test (TST) documented in the healthcare record within the last year. All five records also reflected the Tier I TB screening was completed for each youth on the date of their admission. All five youth were assessed prior to placement in the general population. The results of the TST were documented

on the Comprehensive Physical Assessment (CPA) and Infectious and Communicable Diseases (ICD) forms.

The nurse explained the date of the last screening is verified at admission. If it has been more than a year since the last screening, the youth is given a TB test per standing orders which are initiated upon admission. Youth are also to have a TB test annually. If the youth refuses the TB test, an order for a chest x-ray is obtained.

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

Five youth records were reviewed for sexually transmitted infection screenings. All five youth were screened, and testing was ordered and performed on their admission date. Testing and screening results were documented on the Infectious and Communicable Diseases (ICD) form. Referrals were documented on the STI, and lab results were filed in the Individual Healthcare Record.

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

Five youth records were reviewed and in each there was documentation to support each youth was offered counseling, testing, and treatment for HIV. All five youth were offered HIV testing; however, only three consented. In these three records, the HIV test results were filed in a confidential manner (in a sealed envelope marked confidential and placed in their healthcare record). For the three youth who were tested, their records contained documentation of their consent to be tested. These three records also contained documentation of pre and post-test counseling in the youth's health education record. None of the youth's HIV statuses were documented in the internal alert system. River Region provides HIV pre and post-test counseling services and testing on-site. Five youth were interviewed and all five were aware they could ask for an HIV/Aids test.

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

Five youth records were reviewed and three contained documentation of youth submitting a sick call request. None of the three youth presented with a similar sick call three or more times within a two week period or complained of any severe pain with which staff were unfamiliar. The completed sick call request forms were filed with the progress notes in the youth's healthcare record in reverse chronological order. The program has regularly scheduled sick call hours seven days a week from 12:00 p.m.-12:30 p.m. and 3:00 p.m.-5:00 p.m. A licensed nurse conducts sick call.

Five youth were interviewed, two reported they are seen immediately once they make a sick call, and to reported they are seen within one day. One youth had never requested sick call.

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

Five records were reviewed and three were applicable for youth submitting a sick call request. A registered nurse conducted the sick call in each of the three records reviewed. Sick call forms documented vital signs, treatment education, and follow-up plans. Sick calls were each documented on the Sick Call Index. The youth signed the sick call form reflecting they were seen for their medical concern. The completed sick call forms were filed with the progress notes in the youth's healthcare records in reverse chronological order.

A sick call was observed during the annual compliance review. The nurse, who is PAR certified, escorted the youth to medical. The nurse stated why the youth was there based on the sick call request he had submitted. The youth was seen in a private area (medical department) with no other youth present. The youth was examined and interviewed by the nurse. The youth was asked to sign they were seen at the conclusion of the visit.

Five staff members were interviewed and all five reported the nurse conducts sick call.

4.20 Room Restriction/Controlled Observation	Non-Applicable
All youth in Room Restriction/Controlled Observation shall have timely access to medical care, as required by the Department.	

Room restriction or controlled observation is not used at this program; therefore, this indicator is non-applicable.

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

The program has a policy and procedures regarding episodic and emergency care. Five youth records were reviewed, and documentation reflected three youth received on-site first aid or episodic care. For each record, the progress note contained the following information: date/time of episodic care, nature of the complaint, findings of the person rendering care, treatment rendered, and the name and credentials of staff providing care. None of the three youth required a referral for off-site care. In two records, the youth was provided with education/instructions. In one record, the youth was placed on the alert list (sports restriction). Each of the three youth were instructed to follow-up with another sick call if their symptoms continued or worsened. On-site care was provided by licensed healthcare staff and was documented in problem-oriented (SOAP elements) format. A review of the episodic care log for the past six months reflected all instances of episodic care in the sample of records reviewed were documented.

The program has one automated external defibrillator (AED) which is located in the administration hallway. The program has ten first aid kits which are located in the following areas: maintenance, medical, classroom one, classroom two, master control, backpack in master control, and three additional kits located in master control, one assigned to each transport van to be taken when the van is used. First aid kits are fully stocked with approved contents to include: gloves, cardiopulmonary resuscitation (CPR) mask, eye wash, hand sanitizer, band aids, biohazard bag, gauze, tape, and ointment. A review of documentation

found first aid kits were inspected weekly by a registered nurse. The contents of each first aid kit are listed on the outside including their expiration dates.

Five youth were interviewed and all five indicated they can see a dentist if they have tooth pain, or a doctor, if needed.

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

The program has a policy and procedures regarding emergency care. The program has one automated external defibrillator (AED) located in the administration hallway. The Health Services Administrator (has) and nursing staff are responsible for ensuring the AED batteries and pads are operable. Emergency numbers are posted in each department and master control and are inaccessible to youth. The AED instruction manual is kept with the AED. Nursing staff checked the expiration dates in front of the annual compliance review team member during the review. The AED battery has an install before date of March 2020. The battery was last changed on December 2016. The pads had an expiration date of September 2020. The AED pads were last changed on October 2018. There was documentation that AED checks are completed monthly.

Medical drill documentation was reviewed and reflected medical drills were completed monthly on each shift. All of the drills documented all required elements. At least once a quarter, the mock emergency drill included cardiopulmonary resuscitation (CPR)/AED demonstration.

Five staff were interviewed and asked if they are personally allowed to call 9-1-1 if a youth has a medical emergency. Four reported yes, and one stated no, they would notify their supervisor.

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

Five youth records were reviewed, of which two records contained documentation of off-site care. Therefore, an additional record containing off-site care was reviewed. In two of the three records, parental notification was completed. In the remaining record, the youth was eighteen years old, and did not require parental notification. The summary of off-site care form was utilized and filed in the youth's health care record. Documentation reflected the DHA reviewed and signed all off-site care findings, instructions, and information.

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

Five records were reviewed, of which three youth were identified as having a chronic condition. All five youth were classified with a medical grade of two-five. Each of the youth received periodic evaluations at intervals of no greater than three months with medication management evaluations occurring every thirty days, and evaluations for asthma and obesity occurring every

two months. Periodic evaluation documentation was maintained in each youth's healthcare record. Treatment orders were written clearly and distinguishable for clinical staff. There was no indication of lapses in care or missed periodic evaluations.

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

Five youth records were reviewed. Four youth were taking medication at the time of admission. The youth were transferred into the program from a Department facility and, therefore, medication was deemed verified and confirmed by the Department. Upon each youth's admission, the Designated Health Authority (DHA) was notified to resume youth medication. In each of the four applicable records, nursing staff were on-duty at the time of the youth's admission and the DHA was notified.

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

All medications have a current, valid order and are given pursuant to a current prescription. When medications were continued, discontinued, changed, or new ones are ordered, the Designated Health Authority (DHA) placed an order. In two records, over-the-counter medications not listed on the Authority for Evaluation and Treatment (AET) form were administered in accordance with approved protocols.

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

Medication storage was observed. All medications are in a separate, secure area which is inaccessible to youth. The program does not have any narcotics or other controlled medications. Oral medications are not stored with injectable or topical medications. The medical department has a secured refrigerator for the storage of medication only. Syringes and sharps are secured in a locked box within a locked cabinet.

The nurse explained the process for disposal of expired or discontinued medications is the medications are either returned to the pharmacy for credit, if applicable, or destroyed on-site in the medication disposal container.

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

Medications, sharps, and all over-the-counter (OTC) medications are inventoried weekly. The program does not have any controlled substances requiring a shift-to-shift inventory. Syringes and sharps are counted whenever used, using a perpetual inventory. Syringes and sharps are also counted weekly. Inventories from the past six months were reviewed and found no discrepancies. The program has procedures in place for the disposal of narcotics and other

controlled substances. OTC medication administrations are documented. Inventory was reviewed of three youth medications, three OTC medications, and three sharps. All counts matched the inventory.

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

The program has a policy and procedures regarding controlled medication inventory. The policy articulates counts should be conducted shift-to-shift. The program does not have any controlled medications. One applicable youth record was reviewed for a youth who entered the program on a controlled medication. Documentation indicated perpetual counts, shift-to-shift, were conducted until the medication was discontinued thirteen days later.

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

For each of the five youth records reviewed, the Medication Administration Record (MAR) contained the following elements: youth name's, Department identification number, date of birth, youth allergies, precautions, medical grade, and current picture of the youth. Four of the youth were taking medication at the time of their admission, and their initial MAR matched the medication list. Each of the five youth MARs indicated the youth received medications, as ordered, and the MAR clearly indicated medication start and stop dates. Nursing staff initialed each administered medication entry, and documented side effect monitoring at each administration of medication. There were no indications of lapses/errors in medication administration. There were no documented refusals on the MARs.

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

Medication administration occurred as scheduled. Morning medication pass was observed during the annual compliance review. The working space was clean and organized. The nurse had control of the medication containers and the cart. There was a structured procedure for youth to approach the nurse one at a time. The Five Rights of Medication Administration were verified for every youth. MAR verification, allergy and alert status were verified, and nursing staff questioned youth regarding side effects. The nurse observed the youth to make sure medication was swallowed, and additionally the staff checked to ensure the medication was swallowed. No medications were pre-poured from the original packaging and placed in another container for subsequent administration.

Five youth were interviewed and four reported taking medication. These four youth indicated the nurse provides the medication. The four youth were able to describe the process for receiving their medication.

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

The program has a policy and procedures regarding non-licensed staff providing medication. Non-healthcare staff may only distribute medication when there is not a licensed nurse on-site. Those staff who have been trained to do so are listed by name and title and may only assist youth with self-administration of oral, topical, or inhaled prescribed medication. Currently, non-licensed staff who have access to routine medications include the Facility Administrator, Assistant Facility Administrator, four Shift Managers, a Youth Specialist II, the Recreation Therapist, and a Case Manager. There were no instances of non-licensed staff administering medication during the annual compliance review period.

Five staff were interviewed, and all five reported nurses provide medication. Additionally, one stated a supervisor may provide medication and one stated supervisors who have been trained and only in the event a nurse is unavailable may provide medication.

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

Three youth entered the program on prescribed psychotropic medication. The DHA and Psychiatrist were notified upon each youth's admission. The medications these youth were receiving were continued until an initial diagnostic psychiatric interview was conducted. The initial diagnostic psychiatric interview was conducted within fourteen days of the youth's admission. Additionally, each youth received medication monitoring by the Psychiatrist. One youth was referred to the Psychiatrist and prescribed psychotropic medication subsequent to admission. This youth received an initial diagnostic psychiatric interview within fourteen days. The youth's parent/guardian never provided consent to begin the medication, and subsequently, the youth admitted to drug seeking behavior. The psychiatric evaluation was documented on the Clinical Psychotropic Progress Note (CPPN). The form included the following information: diagnosis, target symptoms of each medication, evaluation and description of effect of prescribed medication on target symptoms, prescribed psychotropic medication, side effects, adherence to the medication regimen, height, weight, blood pressure, laboratory findings, telephone contact with parent/guardian to discuss medication, signature and date, and documentation of monitoring for tardive dyskinesia. There is a comprehensive process in place for the monitoring of psychotropic medications to ensure youth's safety. There are not standing orders for psychotropic medications, emergency treatment orders for psychotropic medications, nor PRN orders for psychotropic medications.

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

The program has infection control procedures in place to include prevention, containment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention guidelines. The infection control procedures include the following: common, infectious diseases of childhood, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis and HIV infectious diseases caused by blood-borne pathogens, outbreaks or epidemics caused by any other infectious agent, whether spread directly or indirectly, outbreaks of lice or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposures in the workplace. The plan also provides that hepatitis B immunizations are available for staff, and staff have access to protective equipment. There were no instances in which the local county health department, CDC, and/or the Central Communications Center should have been notified of an infectious disease at the program.

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

A review of five youth records revealed each youth received health education regarding prevention of communicable disease and prevention of blood-borne pathogens. The program's comprehensive Infection Control Education Plan includes pre-service and in-service training for all staff, and youth infection control education, as per Center for Disease Control guidelines. A review of five pre-service and five in-service staff training records supported staff received the required training.

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

The program's exposure control plan is written in accordance with OSHA standards. The exposure control plan is available to all staff. A coversheet was signed by administration and medical staff annually listing the exposure control plan as being reviewed. The exposure control plan included risk assessment and methods of compliance. There is a comprehensive process in place for needle stick post-exposure evaluation. There were not three or more cases of reportable infectious diseases which needed to be reported to the local county health department and or the Centers for Disease Control and Prevention. There were also no instances involving the quarantining or hospitalization of at least ten percent of the total population of youth or staff.

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

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

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

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

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures addressing youth supervision. According to the written policy and procedures, staff to youth ratios are as follows: 1:8 during awake hours, 1:12 during sleep hours, and 1:5 for off-site activities, visitation, or when separated from the population. The written policy and procedures defines active supervision as the use of effective and efficient supervision which includes positive contact, positive reinforcement, structured activities and random/predictable movement which provides suitable and timely response to the everyday needs of the youth and immediate response to emergencies while maintaining the safety and security of the program. All observations of youth and staff interactions during the week of the annual compliance review were positive. Staff verbally redirected youth and youth complied with staff verbal redirections. Observations and informal interviews confirmed youth to staff ratios were in compliance. Staff were able to immediately tell annual compliance review team member how many youth they were supervising when asked. The posted schedule was full of activities. Observations throughout the review week found the schedule was followed. The staff were observed documenting youth points on point sheets and actively supervising the youth. 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 of the staff indicated the count is reconducted until the count is reconciled. Observations found the counts were conducted at scheduled and unscheduled times.

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

The program's behavior management system (BMS) fosters accountability for behavior and compliance with the residential community's rules and expectations. The BMS was observed posted on the dorm and is clearly explained in the resident handbook which is accessible to youth. The program's BMS details the rules and the positive and negative consequences for actions. Ten training records were reviewed. All staff training records contained BMS training. All five interviewed staff confirmed training and understanding of the BMS. Informal interviews with staff during the annual compliance review week confirmed their understanding and implementation of the BMS. The orientation checklist documents the BMS is reviewed with the youth. All youth case management records contained a complete orientation checklist. The BMS promotes youth rights, positive, negative consequences, constructive disciplinary action, opportunities for reinforcement, provide youth with pro-social acceptable alternative behavior.

The youth have an opportunity to explain their behavior. The BMS is connected to the youth's individual performance and treatment plan goals. The BMS includes a variety of rewards including daily snacks, verbal praise, special privilege activities, and off campus incentive trips. The Facility Administrator interview confirmed the BMS is a level/point system with daily and weekly incentives. All five interviewed youth confirmed their understanding of the BMS. The program provides opportunities for positive reinforcement and recognition of accomplishments and positive behaviors at a minimum ratio of four-to-one (4:1) positive to negative consequences. Four youth rated the BMS fair to very good. One youth rated the BMS very poor.

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 written policy and procedures, the program does not use room restriction or controlled observation, which was confirmed by youth and staff interviews and observations. The points sheets are kept on the dorm during the week. At the end of each week, the point sheets are tallied and filed in the youth's case management record. The Recreation Therapist tallies weekly points prior to the points sheets being filed in youth's records. Youth and staff interviews confirmed their understanding of the behavior management system (BMS). The Facility Administrator interview confirmed rewards are tracked daily and the program tracks the number of youth making their day/week in the BMS database. The Facility Administrator interview confirmed consequences are monitored during the morning management meeting, as well as during special and regular treatment teams. The program's BMS is not used solely to increase a youth's length of stay. Behaviors positive and negative are reviewed during treatment teams. Each of the five interviewed staff indicated they received feedback on their implementation of the BMS daily and as needed. A review of position descriptions specifying required qualifications of staff whose job functions includes implementation of the program's BMS. The qualifications varied by position from high school diploma to college degrees. The program's BMS includes a process wherein staff explain to the youth the reason for any sanction impose. The youth are given an opportunity to explain their behavior, and staff and the youth discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternative acceptable behavior. All five interviewed staff indicated there are a variety of reward and incentives for good behavior.

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-two cameras. Twenty-one cameras were operational at the time of this review. The work orders, budget requests, and bids have been submitted to fix the nonoperational cameras. The video coverage storage goes back ninety days. The program's practice is to conduct checks every eight minutes. The video was reviewed on different dates and various times on each shift. A total of forty-six of forty-eight ten minute checks were completed, as documented. There were two checks documented on January 27, 2019 at 6:28 a.m. and 6:36 a.m. which were not competed as documented on the ten-minute check form. The staff responsible for documenting the checks during this time no longer works at the program. The Facility Administrator called the Central Communication Center (CCC) with reviewer present and the report was accepted. Based on observations of ten-minute checks, this was an isolated incident and not a systemic issue. Each of the five interviewed staff indicated checks are complete at eight-minute intervals.

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

The program's written policy and procedures were reviewed. 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 logbooks. Logbooks for the previous six months were reviewed and found no discrepancies. Informal and formal counts were observed during the annual compliance review and found they were each conducted as required. Five of five staff interviewed confirmed staff know the procedures for reconciling the count if there is a discrepancy.

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

Logbooks from September 2018 to March 2019 were reviewed. All of the logbooks were bound. All entries were in ink. There was no evidence of eraser marks. 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. In the front of each logbook, there is a page for documenting weekly reviews of the logbooks. The weekly review forms were competed in each logbook; however, the signature for the facility administrator was missing on the cover page for the November 2018 logbook. The logbook pages documented perimeter checks, weather alerts, central communications reports, shift summary notes, keys, radios, drills, Prison Rape Elimination Act (PREA) checks, fire safety, and scheduled and unscheduled counts, and any calls made to the Florida Abuse Hotline and Central Communications Center (CCC). The program does not maintain a living unit logbook.

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

The program's written policy and procedures addressed distribution, tracking, storage, and overall control and security of keys. A review of the inventory matched the key rings in use. The keys are kept in a secure area in the master control area which is not accessible to youth. Each set of keys has an assigned key hook. Keys are assigned to staff according to their department. The master control operator reported 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 was verified by the review of internal incident reports and Central Communication Centers (CCC) reports. The physical plant manager is responsible for replacing broken or damaged keys. Informal interviews with staff confirmed staff's knowledge of the key rings and assigned keys. All observations during the review week found personal keys were secured and staff were aware of program keys in their possession and followed the key control procedures. 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.

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

The program has a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and youth which is clearly explained in the program's policy and procedures, and resident handbook. The policy also includes any staff who is found in possession of contraband in a program will be subject to disciplinary action up to, and including, dismissal. The program defines items and materials considered contraband when found in the possession of youth, provides youth with a list of contraband, and informs youth of the consequences if found with contraband. The prohibited list includes personal cell phones and/or equipment and/or electronic devices capable of taking pictures and/or audio/video recordings, which are prohibited in the secure area. Staff were able to explain the contraband procedures. 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 was only one exception on January 13, 2019, where the youth search forms were not filled out completely. One incident of illegal contraband in the last six months and law enforcement was contacted as outlined in policy procedure and documented according policy and procedures. The youth's family member's visitation privileges were suspended, and the program notified the family member by phone call.

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

The program has a written policy and procedures addressing searches. Observations during the annual compliance review found searches were completed prior to and after movement from one area to another. Video of a transport was reviewed and found searches were completed according to policy and procedures. Observations found searches were conducted in a manner which treated the youth with dignity and respect. Searches were conducted in accordance with Protective Action Response (PAR) training manual. Four of five interviewed youth indicated searches are competed after off campus trips, outdoor activities, when items are missing, after

visitation, and after meals. Two youth also indicated searches are conducted after work detail. Additional comments as to when searches occur included before and after movement and at unexpected times. Five of five interviewed staff reported searches are conducted before and after every movement.

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

The program has three vans; however, one van is not used for transports at all. Each van had an annual safety inspection. The annual safety inspections were observed completed as follows: van one on August 1, 2018, van two on August 1, 2018, and van three on November 29, 2018. All vans observed were secured when not in use. The two vans used for transports contained a fire extinguisher, seal belt cutter, window punch, and appropriate number of seat belts. Each van had an assigned first aid kit which is kept in master control. All five interviewed staff confirmed youth are not transported in staff's personal vehicles.

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

The program's written 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 (FDJJ 1920). A video of a transport was reviewed. Staff of the same gender completed the transport. Two staff and one youth were on the transport for new admission. The youth was transported with mechanical restraints, as the youth was a new admission. A check of all the cars in the parking lot found all the cars were locked. 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 completely filled out and documented searches and vehicle's safety, ratio maintained during transports, cell phone, and transporters of same sex as youth. Five of five staff interviewed confirmed youth are not transported in staff's personal vehicles. Additionally, staff reported they are issued a facility cell phone and radio when going on transport.

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

The written policy and procedures clearly designates the physical plant manager for conducting the weekly security safety and security audits. Weekly audits binder reviewed. Since

September, there was only one weekly inspection missing for the week of December 23, 2018. The program has two forms used to document weekly inspections. The forms documented safety and maintenance repairs needed and the date and time the repairs were completed. The program has documentation of on-going efforts to fix the cameras which are not operational. The weekly safety audits are kept in a binder. All the forms were reviewed and signed by the Facility Administrator. The forms cover radios, cameras, keys, telephones, mechanical restrains, generator, flashlights, fire safety equipment, alarms, ensuring no anchor points, youth rooms, recreation area, grounds, correction action needed, and corrective action completed. The interview completed by the Facility Administrator confirmed the weekly safety audits are conducted in accordance with program 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 written policy and procedures in place to ensure youth use of tools safely and youth are supervised appropriately to prevent injuries to the youth, other youth, and staff. All observations during the annual compliance review week found all tools were secured when not in use. Class B tools, mops, and brooms are in a closet by the bathroom on the dorm and in the kitchen. The inventories and sign-in-sheets for the previous six months were reviewed. All the class B tools matched the inventory. Class A tools are in the kitchen in a locked cabinet in the food manager office and in the maintenance area, which are both areas not accessible to youth. The class A tools are on shadow boards. The class A tools are inventoried. The inventories and sign-in out tools for the previous six months were reviewed and were complete. A random check of class A tools in the kitchen and in the maintenance area was conducted and found all items matched the inventory lists. The physical plant manager indicated there have not been any reports of damaged or dysfunctional tools. Five interviewed youth reported they use the following tools: mops, brooms, lawnmower, and vacuum.

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 written policies and procedures in place to ensure youth use tools safely and are supervised appropriately to prevent injuries to the youth, other youth, and staff. The orientation checklist addresses the use and training of tools. Each youth record reviewed contained a completed orientation checklist. Staff were aware of the ratios during activities involving tool use: 1:5 and disciplinary work projects: 1:3. The were no disciplinary work projects during the annual compliance review week. The youth risk assessments for off campus and use of tools are maintained in a binder. The binder was reviewed. All the forms were completed according to the programs policy and procedures. Each of the five interviewed youth confirmed the youth use mops and brooms. One youth reported using the lawn mower. The physical plant manager conducts training with youth prior to the use of lawn mower. 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's written policy and procedures address when an outside repairman or worker enters the program to perform a work project requiring the use of tools. 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. Personal cellular phones and/or 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 maintains a binder which contains all notice of tools equipment instructions forms which the outside contractor must sign. The binder was reviewed. The dates of the work invoices matched the sign-in sheets of the outside contractors. Only one form had not checked if they final inspections of work area completed. The tool notice forms also addresses the following: tools checked upon arrival and departure, tool restrictions while in the facility, youth are 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.	

Drills are conducted in accordance with the program's disaster plan or Continuity of Operations Plan (COOP). Another source specifying how drills might be conducted are the facility operating procedures. Fire drills are conducted monthly on each shift. The 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 scope of the annual compliance review, in accordance with the COOP. Three of five interviewed youth indicated they know what to do in case of fire. Two youth indicated fire drills are conducted monthly. All five interviewed staff reported they have participate in the following drills: weather, bomb threat, escape, fire, medical, and suicide drills. The Facility Administrator reported fire drills are conducted monthly and 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.	

The Continuity of Operations Plan (COOP) is located in master control. The plan addresses alternative housing plans approved by the applicable DJJ Regional Director/designee. The plan was approved by the residential regional director on May 11, 2018. The annexes were updated on March 4, 2019. The COOP addresses: fire prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats

or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The program 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 severe weather. The program has food and necessary supplies readily available in case of emergency evacuation. The Facility Administrator reported the COOP is located in master control.

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

Chemicals are secured and inventoried as outlined in the program's policy and procedures. All chemicals were observed to be secured during the annual compliance review. The flammable items are stored in a locked cabinet behind a locked gate in the maintenance area, locked closet in the kitchen, and locked closet in the dorm by the bathrooms. The flammable materials located in the maintenance area are secured in a cabinet. A random sampling of the chemicals in each area found the inventories to be accurate and up to date. The inventories were reviewed for the previous six months. Staff and youth interviews confirmed the youth do not use or have access to chemicals. Safety data sheets were in each storage closet where chemicals were stored. The safety data sheets matched the chemicals in each storage area.

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 maintains strict control of flammable, poisonous, and toxic items and materials. The program policy procedures indicated youth are not allowed to or have access to chemicals. Observations throughout the review week confirmed the youth do not use or have access to the chemicals. Five youth were interviewed in regard to the use of these materials. Each of the five interviewed youth reported they do not use any chemicals. All five interviewed staff reported youth do not use chemicals.

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

The program's policy and procedures on the disposal of flammable, toxic, caustic, and poisonous items are in accordance with Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030. 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 physical plant manager has not had to dispose of any chemicals other than dirty mop water which can be poured down the drain. The program does not use grease for cooking. The physical plant manager indicated if they had waste to dispose of, he would take it to the household hazardous waste site. The Facility Administrator reported waste is disposed of safely, using an approved vendor or dump station and the item will be documented to include the manner in which it was disposed of.

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

The program promotes the active participation of youth through opportunities to make choices, assume meaningful roles, including team membership and leadership roles, and give input into the rules and operation of the residential community. The program employs a Recreational Therapist who meets the required credentials outlined in the program's contract. The Recreational Therapist works with the youth individually and in groups and plans a variety of activities which encourages team work, leadership, and pro-social skills and decision making. Recreation was observed during the annual compliance review week. The youth were observed playing basketball. The program utilizes "let's talk" forms which allow youth to give formal input in regard to activities. Therapeutic activities were incorporated into the youth's performance plans. Five interviewed youth reported they can participate in basketball, card games, board games, football, soccer, baseball, large muscle movement, and frisbee. The youth also indicated they have at least one hour of large muscle activity each day. Five staff interviewed confirm youth have a least one hour of large muscle activity a day and participate in a variety of activities.

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

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

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

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

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

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

The program's written policy and procedure states it does not allow youth to participate in water-related activities, therefore, this indicator is non-applicable.

5.23 Visitation and Communication	Satisfactory Compliance

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

The visitation procedures are posted on the front gate and on the wall in the lobby. The visitation and communication procedures are covered in the resident handbook and addressed on the orientation checklist. The weekly telephone calls to parents/guardians are documented in the youth case management records in the chronological notes. Five youth case management records were reviewed. All contained documentation of weekly phone calls to parents/guardians or family members. Each of the five interviewed youth confirmed they have opportunities to contact their family by phone and during visitation. Visitation is held on weekends and was not able to be observed during the annual compliance review.

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

The program does not utilize controlled observation; therefore, this indicator is rated as non-applicable

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

The program does not utilize controlled observation; therefore, this indicator is rated as non-applicable

5.26 Controlled Observation Safety Checks Release Procedures	Non-Applicable
The program shall conduct safety checks for youth on Controlled Observation. The Facility Administrator 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 does not utilize controlled observation; therefore, this indicator is rated as non-applicable.

Program Name: Jacksonville Youth Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Duval County / Circuit 4
Review Date(s): March 12-15, 2019

MQI Program Code: 1293
Contract Number: 10138
Number of Beds: 24
Lead Reviewer Code: 168

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.17 Educational Access	