STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Jacksonville Youth Academy

TrueCore Behavioral Solutions, LLC
(Contract Provider)
4501 Lannie Road32218
Jacksonville, Florida 32218

Review Date(s): March 10-13, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Kristine Harshaw, Office of Program Accountability, Lead Reviewer (Standard 1)
David Cook, AMI Kids Jacksonville, Director of Education (Interviews)
Renette Crosby, Office of Program Accountability, Regional Monitor (Standard 4)
Kimberly Lambert, DJJ Probation, Juvenile Probation Office Supervisor, Circuit 5 (Standard 2)
Tara Gilligan, Office of Program Accountability, Regional Monitor (Standard 5)
Mike Marino, Office of Program Accountability, Regional Monitor (Standard 5)
Gwen Nelson, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Jacksonville Youth Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Duval County / Circuit 4
Review Date(s): March 10-13, 2020

MQI Program Code: 1293
Contract Number: 10138
Number of Beds: 24
Lead Reviewer Code: 187

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.26 Safety Planning Process for Youth	5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	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/Consent	Satisfactory
4.05	Healthcare Admission & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	Designated Health Authority/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Illness/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exposure Control	Satisfactory
4.18	Prenatal Care/Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Jacksonville Youth Academy is a twenty-four-bed program, for males fourteen to nineteen year old, 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, behavioral health, and substance abuse treatment services. In addition, the program fosters each youth by providing Impact of Crime, Cannabis Youth Treatment, and Male Healthy Relationships. Additional treatment services provided include 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 transitional services manager 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. Medical staffing includes three full-time registered nurses (RN) and a contracted osteopathic physician (DO) who serves as the program's designated health authority (DHA). Educational services are provided by the Duval County School District. The layout of the program includes: one building which contains the dormitory, kitchen, cafeteria, medical unit, and case management, mental health, 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-three of which were operational and providing coverage. At the time of the annual compliance review, the program had seven vacant positions: two youth care worker Is (YCW I), four YCW IIs, and one therapist.

Standard 1: Management Accountability

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

The program has a written policy and procedures addressing pre-employment background screenings. Nine applicable staff records were reviewed for background screenings. All nine records 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 to direct care applicants. Each of the four direct care staff received a passing score on the pre-employment assessment tool. The program's Annual Affidavit of Compliance with Level 2 Screening Standards was completed for the program and sent to the BSU on December 11, 2019. The Annual Affidavit of Compliance with Level 2 Screening Standards for education staff was completed and sent on December 13, 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. Three staff at the program required a background rescreening during the annual compliance review period. All three staff received a rescreening within twelve months of their five-year anniversary of the initial agency hire date.

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

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

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

The program has a written policy and procedures to ensure program-related incidents, which place at risk, or have the potential to place at risk, the health, safety, or welfare of the public or of youth, staff, or visitors, the security of the facility, or the reputation of the provider are reported and handled appropriately and in a timely fashion. According to the written policy and procedures, abuse reporting procedures are as follows: any staff who have knowledge of, or has a reasonable suspicion a youth has been, is being, or is in danger of being abused, should immediately report it to the Florida Abuse Hotline (for youth under the age of eighteen), or the Central Communications Center (CCC) Hotline (for youth eighteen years of age or older). If a youth is requesting to contact the Florida Abuse Hotline, policy states staff are to notify the staff mentor (supervisor), who will assist the youth in making the call. The program has had one substantiated instance of physical, psychological, or emotional abuse since the last annual compliance review. Staff adhere to a code of conduct, as indicated in the receipt of the employee handbook contained in the staff record. All five reviewed pre-service records reflected staff received training on child abuse reporting. The Florida Abuse Hotline and CCC numbers were observed posted throughout the facility. Four of five interviewed youth reported they feel safe in the program. The remaining youth said he didn't feel safe due to other youth in the program. All five youth reported they have never been prevented from making a call to the Florida Abuse Hotline. Four of the five youth reported staff are respectful when talking with youth. The remaining youth indicated all but one staff are respectful and he has heard staff use profanity. Each of the five staff interviewed were familiar with the program's abuse reporting procedures. Staff reported they have never observed a co-worker denying a youth the right to an abuse call, and four out of five reported they have not witnessed their co-workers using profanity or threatening behavior when dealing with a youth. The facility administrator reported youth and staff are given instruction on abuse reporting at respective orientations, and annually thereafter for staff.

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

The program had three reported allegations of abuse, of which one was found substantiated. In all three instances, program administration took immediate action by removing the staff from contact with youth. One reported incident was found to be unsubstantiated. In the second incident, one staff was terminated for verbal threats. For the remaining incident, the staff resigned after being removed from contact.

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

The program has a written policy and procedures 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 eighteen incidents reported to the Central Communications Center (CCC) during the previous six months. A sample of five incidents were reviewed. All five incidents were reported within two hours. Documentation in the facility logbooks was found for all five CCC reports. The program has 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. He also reported significant incidents impacting operational safety and security are reported internally, and for qualifying incidents, to the CCC. The program has a practice of calling the CCC if they need clarification in regards to whether an incident is reportable.

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 had three incidents of utilizing Protective Action Response (PAR) techniques during the previous six months. Five PAR reports were reviewed. Three reports from the previous six months and two from the month prior to the six-month review period (August). Four of the five reports were completed by the end of the staff member's shift and included statements from all staff involved. One report was completed nine days late; however, corrective action was taken with all involved. Mechanical restraints were not utilized in any of the PAR incidents. None of the reports resulted in an allegation of abuse. All five reports reflected a review by a PAR certified instructor/supervisory staff and post-PAR interviews were completed with the youth involved within thirty minutes of the incident. Four of the five reports were reviewed by the administrator or designee within seventy-two hours of the incident. One report,

which was completed late, was reviewed by the administrator the date it was completed. Two of five reports indicated the need for a PAR Medical Review, for which medical reviews were 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 2020 year was approved by the Department on March 28, 2019. The program's PAR rate for the previous quarter was 1.31, which is below the statewide residential rate of 2.41. According to the facility administrator, all PAR reports are reviewed and compared to video surveillance of the incident. The facility administrator added, the program follows up appropriately if use of PAR is unwarranted or improper.

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

The program has a 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 must complete a minimum of 120 hours required training within the first thirty days of employment. Training documentation was available for review within the Department's Learning Management System (SkillPro). All five reviewed pre-service training records indicated all of the staff had in excess the required 120 hours within their first thirty days of employment. 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. 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 April 12, 2019.

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

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. Three 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. One staff member's training documentation reflected four hours of suicide prevention delivered through an instructor, but not the additional two hours of required training in the Department's Learning Management System (SkillPro). Both staff members completed the other required trainings (CPR/AED, etc.); however, were missing one part of the

suicide prevention training. All five in-service training records reflected each staff completed over twenty-four hours of annual training. The program had three applicable supervisory staff at the time of the annual compliance review. Two of the three staff had more than the required eight hours of supervisory training in the areas of management, leadership, personal accountability, employee relations, communication skills, and fiscal training. One supervisor was new to the position and had completed six hours of supervisory training in his first thirty days in the position. The program employs three registered nurses (RN), all of whom have current certifications for CPR with AED. All training, besides the exceptions 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 and the training plan was signed on April 12, 2019. 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 timely manner and resolved to the best interest of the youth, the program, and the Department. The program's grievance process includes an informal phase, including verbal dialogue and "Let's Talk" forms, and a written or formal and appeal phase, in which youth utilize the grievance form. According to the written policy and procedures, the program has seventy-two hours to handle informal and formal grievances. The program reviews all grievances during morning management meetings and are followed-up on within twenty-four hours. The program has had seven grievances filed within the previous six months. Two grievances reviewed were related to a youth being unhappy with the food being served, two were in reference to safety concerns, one was a complaint about the education department, one was an issue with clothing, and the last one was related to a medication error. Five grievances were reviewed and all were responded to and/or resolved the same day the grievance was submitted or within twenty-four hours. Each grievance was 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 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 forms location and the procedures. According to the facility administrator, youth can informally handle a grievance verbally or through "Let's Talk" forms.

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

The program provides Impact of Crime (IOC) and Cannabis Youth Treatment (CYT). These groups are classified by the Department as evidence-based or a promising practice and provided as contractually required. The program previously provided Life Skill Training (LST), an evidenced-based curriculum, though this was discontinued in August 2019 with the Department's approval, as life skills are covered in the gender-specific group, Male Healthy Relationships. The program's clinical director received training in Male Healthy Relationships and Impact of Crime, has a master's-level education, and has over ten years of experience working with adult or juvenile offenders. The program has one master's-level therapist with decades of experience working with adult or juvenile offenders. This therapist received training in Impact of Crime, LST, and Male Healthy Relationships. The program's case managers have received training in CYT, LST, and IOC, have a bachelor's-level education, and several years of experience working with adult or juvenile offenders. Education and work experience are considered by the administration 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 substance abuse 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 facilitate IOC and LST, while therapists facilitate CYT.

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

A review of the 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 up until August 2019. LST was replaced by Young Men's Work and Living in Balance. Each of the five reviewed youth records reflected all 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.

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 was receiving, or has 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, a program for local at-risk youth, to speak on the impacts of their crimes to at-risk youth. Youth also attended a program where they heard a commitment manager from the Department speak. A review of five 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.

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

A review of the program's contractual agreement found the program is providing 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 groups and education on male health issues, such as testicular exams, sexually transmitted diseases, and male hygiene, were provided.

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 entering alerts in the Department's Juvenile Justice Information System (JJIS). All five youth records reflected alerts were entered into JJIS, as required. All alerts were verified prior to their entering into JJIS. Each of the five youth alerts reviewed were applicable for, and found evidence of, being documented within the program's logbook and shift reports. A review of the program's internal alerts found they were consistent with alerts entered within JJIS. All alerts requiring removal or downgrading were found to have been done so by the appropriate staff member. The facility logbook does, however, contain a field for changes in alert status, which is consistently marked with a zero, even when the alert section and the chronological narrative reflects a change. The facility administrator was interviewed concerning the program's internal alert process, as well as the process of entering alert information into JJIS. The facility administrator stated alerts are entered in JJIS by case management (security), clinical staff (mental health and substance abuse), and medical staff (medical and food allergies), respectively. Those alerts are reviewed daily during management meetings and posted in the staff master control office for review by all incoming staff. He reported dietary alerts are also posted in the kitchen. Five interviewed staff reported they are briefed on youth alerts through briefings with shift supervisors, and the internal alert board located in master control.

1.15 Youth Records (Healthcare and Management)	Satisfactory Compliance

The program maintains an official case record, labeled "Confidential," for each youth, which consists of two separate files:

- *An individual healthcare record*
- *An individual management record.*

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

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

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

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

The program holds Community Advisory Board meetings on a quarterly basis. A review of meeting minutes and sign-in sheets found evidence the program held meetings quarterly. 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. 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 representing the legal system, law enforcement, business, the LBGTQ community, faith based, victims advocacy, and education. The advisory board has brought new programs to the facility, sponsored outings, and provided a joint family day/Christmas party.

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

The program provides youth and parents/guardians surveys to complete in order to utilize data for program planning. The survey results are incorporated into the planning process through sharing of information in monthly all-staff meetings. This information was verified through a review of meeting minutes and agendas. The facility administrator uses meetings as a system of communication to keep staff informed and allow them opportunities to provide input and feedback pertaining to program operations. The program has a staff retention plan, which includes steps to minimize turnover and improve staff morale. These include recognition rewards, incentive rewards, employee referrals, and bonuses. The program also has a written policy and procedures for staff communication to include opportunities for providing input and

feedback on the program's operations. The program communicates important information by shift briefings and daily management meetings. Three of five interviewed staff reported staff meetings were held monthly. Two of the five staff reported they were held daily. The five interviewed staff reported topics of meetings included important and valuable information such as issues with youth, daily activities, changes in policy and procedures, trends, updates, and new staff introductions. Four out of five staff reported they were briefed on Commission on Accreditation of Rehabilitation (CAR) information. Three of five staff reported the communication at the program was good. One staff reported it was poor, and one staff reported it was very good. The facility administrator (FA) reported a high turnover year for the program and morale is challenging because of the vacancies. The FA also reported he is addressing this by employee recognition and appreciation. They accomplish this by bringing in food for staff, especially when there is a hold over. The FA was questioned regarding outcome data used by the facility, and how the information was used for program planning. The FA stated they review the CAR and Monitoring and Quality Improvement (MQI) results, as well as surveys in all staff meetings and work to improve services based on feedback. One example is a change in food vendors in response to youth feedback about the meals.

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 the frequency of evaluations. The program's policy indicates evaluations are to be completed annually, or as deemed appropriate by the supervisor. A review of a sample position 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 supervisors rate staff based on key performance indicators and set goals for each staff to attain beyond these. Five staff were interviewed and asked how often they receive performance evaluations. Three staff reported annually, one staff reported every six months, and one staff reported monthly. Two staff stated they were new and have yet to receive an evaluation.

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

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

documented in the logbook (outside temperatures and conditions, physical plant issues). The program contract includes one recreational therapist position. A review of the program's staffing roster, as well as the therapist's credentials, schedule, and services provided to youth demonstrate all requirements were met. A review five youth records demonstrated the therapeutic activities provided are part of each youth's performance and/or treatment plan. The program has a formal process to promote constructive input by youth.

Five youth were interviewed. Each of the youth agreed there are physical activities and leisure activities provided for at least one hour. Youth described some of the activities to include football, basketball, television, listening to the radio, dodgeball, outings, watching movies, and character building games with treatment staff. Each of the five you also affirmed they are provided with varying degree of mental and physical exertion throughout the day. Five staff were interviewed and each were able to provide an examples what types of indoor and outdoor activities are provided to the youth.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures to address initial contact with a youth's parent/guardian and for court notification upon a youth's admission to the program. The policy requires telephonic contact with the parent/guardian within twenty-four hours of admission. The policy further requires the program's assigned case manager to send written notification and specific program information within forty-eight hours of admission. Five case management records were reviewed. Each record contained documentation of telephone contact with the youth's parent/guardian on the day of the youth's admission to the program. Each record included a letter to the youth's parent/guardian within forty-eight hours of admission. The program also contacted each youth's juvenile probation officers/post-residential services counselor and the committing court within five working days of admission to the program.

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

The program has policy and procedures to address the youth orientation process. The program provides an orientation to each youth on the day of admission, which is completed by a case manager. Youth receive an overview of the program's services and a student handbook, which includes a more detailed description of program services and a review of the rules governing conduct and positive and negative consequences for behavior. The case manager and youth sign an orientation checklist to document a review of each topic. The program's orientation process includes the following topics: services available; expectations and responsibilities of youth; the behavioral management system; availability of and access to medical and mental health services; access to the Florida Abuse Hotline, or if the youth is eighteen years or older, the Central Communications Center (CCC); items considered contraband, including illegal contraband and prohibited items, possession of which may result in the youth being prosecuted; performance planning process; dress code and hygiene practices; procedures on visitation, mail, and use of the telephone; anticipated length of stay in the program and expectations for release from the program, including the youth's successful completion of individual performance plan goals, the program's recommendation to the court for release based on the youth's performance in the program, and the court's decision to release; community access; grievance procedures; emergency procedures, including procedures for fire drills and building evacuation; and the physical design of the facility, including those areas not accessible to youth. The program will assign each youth to a living unit and room, treatment team and, if applicable, a staff advisor or youth group. Five case management records were reviewed. Each record contained documentation to show the youth received an orientation on the day of admission to the program. Each record documented the orientation process, expectations, and responsibilities of each youth. Each youth signed a form to document their review of the orientation checklist and all covered topics. Daily schedules were posted in multiple locations. The program's behavior management system was posted. There were three admissions during

the annual compliance review; however, they were unable to be observed as they occurred after regular business hours with little notice to the program. Five youth were interviewed and all five reported having orientation on the date of admission to the program.

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

The program has a policy and procedures to address consents for youth who are eighteen years of age or older, which requires the program to obtain written consent of any eighteen-year-old youth prior to providing or discussing any information with the youth's parent/guardian. Five case management records were reviewed, but only one was applicable since the youth was eighteen years of age. The program had no additional applicable records for review. The one applicable record contained the signed written consent of the eighteen-year old youth.

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

The program has a policy and procedures to address the classification process and reassessment for activities. The program's classification includes a review of the following factors: physical characteristics, age and maturity level, identified special needs, including mental, developmental, intellectual, and physical disabilities; history of violence, applicable gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, and identified or suspected medical, suicide, escape, or security risk. On the day of a youth's admission, the program conducts an admission classification meeting to discuss classification factors, which is attended by the youth, case manager, and program administration. Five case management records were reviewed. Four of five records contained a completed classification form with all required elements. One of the records did not address the maturity level but addressed all other requirements. Living unit and room assignments were derived from the information gathered from the classification process. Each record contained a Victimization and Sexually Aggressive Behavior (VSAB). Reassessments for classification were completed during monthly treatment team meetings. The facility administrator was interviewed and reported the youths' mental health, physical health, cognitive performance, age, and prior victimization were considered when assigning a youth to a living unit.

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

The program has a policy and procedures to address gang identification, which includes notification of law enforcement. Five case management records were reviewed, but only one was applicable for gang involvement. Five additional records were reviewed. In all six applicable records, the program notified local law enforcement regarding the youth's gang status. The program also provided notification to each youth's juvenile probation officer, local school district, and law enforcement in the home county. The program also maintains a binder with gang information for youth in the program, which identified six youth with gang affiliations. Notifications to law enforcement were documented for each youth and a gang alert was entered into the Department's Juvenile Justice Information System (JJIS) for the applicable youth.

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

The program has a policy and procedures to address a youth's participation in gang prevention and/or intervention activities. Five case management records were reviewed, of which one was applicable for gang involvement. Five additional records were reviewed. In review of the Gang Binder, there are six youth in the program with gang affiliation. All six youth participated in monthly gang prevention and intervention strategies/interventions and have performance plans which addressed gang interventions.

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

The program has a policy and procedures to address the completion of Residential Assessment for Youth (RAY) and reassessments. The policy requires the completion of an initial RAY within thirty days of admission to the program and the completion of a reassessment prior to the program preparing a ninety-day summary. Five case management records were reviewed. Four of the five records supported the initial RAY assessment was completed within thirty days of admission. The remaining record was for a youth who transferred from another residential program, and the program resumed treatment from the prior program (Fort Myers Youth Academy). Of the five records, a RAY reassessment was not applicable for one youth, as he was new to the program. The remaining four records had RAY reassessments completed. Two of the RAY reassessments were completed within ninety days of the initial RAY and two were seven days late. All RAYs and RAY reassessments were completed in the Department's Juvenile Justice Information System (JJIS) and documented in the case record.

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

The program has a policy and procedures to address the completion of a Youth Needs Assessment Summary (YNAS), requiring the completion of the YNAS within thirty days of admission. Five case management records were reviewed and each contained a Youth Needs Assessment Summary (YNAS). Four of the five were completed within thirty days of admission to the program. One YNAS was not applicable due to youth being transferred from another program. Each YNAS was documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures to address the intervention and multidisciplinary treatment team. The treatment teams are required to develop an individualized performance plan within thirty days of admission to the program. Five case management records were reviewed. Performance plans were completed for each youth, with four of the five completed by the program within thirty days of the youth's admission. One performance plan was not applicable for completion within thirty days, as the youth was transferred from another program. All of the performance plans were developed after the initial assessment. Each performance plan was developed by the treatment team, and all relevant members participated during the development, including parents/guardians. Each performance plan included goals for the youth to complete prior to release from the program. The goals were individualized and based on prioritized needs reflecting the risk and protective factors identified during the initial assessment. All performance plans contained target dates for completion of goals, court-ordered sanctions reasonably able to be completed in the program, youth responsibility to accomplish goals, and the program's responsibilities to assist the youth to achieve the goals. Each performance plan included the top three criminogenic needs to be addressed. Each of the performance plans were signed by the youth, treatment team leader, and all parties who had significant responsibilities in goal completion. Three of five performance plans were signed by the parents/guardians; although, the program did mail out the performance plan to all parents/guardians with a request to sign and return the signature page. Each performance plan was sent to the committing court, juvenile probation officer (JPO), and parent/guardian within ten working days of the plan being completed. In the one applicable record, the Department of Children and Families was sent a copy of the youth's performance plan. Five youth were

interviewed. Each youth reported they participated in the development of their performance plan, knew their current performance plan goals, and they had a copy of their performance plan.

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

The program has a policy and procedures to address revisions to individualized performance plans, when determined necessary, by the intervention and treatment team. The policy requires revisions when new criminogenic needs are identified during the Residential Assessment for Youth (RAY) reassessments, when the youth demonstrates progress or lack of progress toward completing a goal, or when new information is acquired or revealed. Five case management records were reviewed. Four of five had a performance plan revision. One did not have a revision because the youth was in the program for a short amount of time and did not warrant a revision. There had been at least one monthly review of each youth due to RAY reassessments, newly acquired information, progress towards completing goals, and/or lack of progress toward goal completion.

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

The program has a policy and procedures to address the requirements for completion of performance summaries every ninety days. The summaries are due within ninety days of the signing of the youth's performance plan, or at shorter intervals, if requested by the committing court. The policy further requires the treatment team to prepare a performance summary prior to the youth's release, discharge, or transfer from the program. The performance summary provides information to the youth, parent/guardian, juvenile probation officer (JPO), and other parties related to the status of each performance goal and describes the youth's overall adjustment to and performance in the program. Five case management records were reviewed, all of which were applicable for the completion of at least one performance summary and transmittal. Each of the five summaries were completed within ninety days of the performance plan. Each of the five summaries contained all of the elements required including the youth's status on each goal, treatment progress, academic status, behavior, level of motivation/readiness to change, interaction with peers, interaction with staff, adjustment to the program, and positive/negative events. Each of the five summaries were signed by the applicable treatment team members, including each youth. Each summary was filed in the case management record. Each of the five summaries were sent to the committing court, juvenile probation officer (JPO), and parent/guardian within ten working days of completion. Each youth was provided a copy of the summary.

One of the five active case management records reviewed, as well as the three closed records reviewed were applicable for release summaries. Each contained a copy of the original summary sent to the JPO along with the Pre-Release Notifications (PRN) at least forty-five days prior to the youth's anticipated release date. Each summary contained the justification for release. The program provided written notification to the parent/guardian of the approval for release. The program completed ~~a new~~an Exit RAY ~~for the exit~~ assessment in each record. The Sexually Violent Predator Program (SVPP) and victim notifications did not apply to the reviewed records. The program provided the performance summary and transition plan to the JPO. Five youth were interviewed. Each of the five reported receiving 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.	

The program has a policy and procedures to address the inclusion of parents/guardians in the case management process. Five case management records were reviewed. In each of the case management records, the case manager sent an admission letter to the parent/guardian, which included the dates/times for treatment team meetings. Each record had documentation to show the parent/guardian was involved in the assessment process and participation in the development of the performance plan. A copy of the performance plan was mailed to each parent/guardian with a request to sign and return the signature page. There was documentation to show the parent/guardian was called for each treatment team meeting. The program has family days quarterly and case managers keep in contact with parents/guardians and promote involvement. Five youth were interviewed. Four of the five youth reported their parents/guardians were involved in the case management process. One youth reported his parents/guardians have not been involved so far (he indicated he has been at the program two months), but this Sunday they will participate in family therapy.

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

The program has a policy and procedures to address the members of the treatment team. The policy identifies the case manager to be the treatment team leader. The program's treatment team members consist of the case manager/treatment team leader, youth, and representatives from program administration, education, the youth's living unit, mental health treatment, education, and medical. The juvenile probation officer (JPO) is also part of the treatment team, and, when applicable, the transition case manager and the youth's parent/guardian or the Department of Children and Families (DCF) case worker are included. Five case management records were reviewed. Each of the records documented the notification to the required participants of the treatment team meetings and who attended. If the parent/guardian and/or JPO did not participate in the treatment team meeting, there was documentation to show attempts to contact the parent/guardian and JPO. All forms contained signatures from required team members.

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

The program has a policy and procedures to address the incorporation of other plans into a youth's performance plan. Five case management records were reviewed. Each record contained a performance plan. Each of the youth's academic plans and mental health/substance abuse treatment plans were referenced in the performance plans. One record was applicable for a Department of Children and Families plan, which was incorporated into the youth's 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 RAY reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions. If the youth has a treatment plan, review their treatment plan progress.	

The program has a policy and procedures to address the provision of intervention and multidisciplinary treatment teams. The treatment teams are required to meet every thirty days to formally review each youth's performance, to include Residential Assessment for Youth (RAY) reassessment results, progress on individualized performance plan goals, and positive and negative behavior, including behavior which resulted in physical interventions. The policy requires the case manager to conduct informal reviews of each youth's performance monthly. The case manager meets with the youth during informal reviews and uses input from treatment team members, as needed. Five case management records were reviewed. Each of the records documented formal treatment team reviews were held at least every thirty days. Treatment team documentation included the youth's name, date of review, comments from treatment team members, progress in the program, progress of goals, behaviors, skills, treatment progress, and RAY results. Each of the five records had informal reviews. Documentation of informal reviews included the youth's name, date of review, comments from treatment team members, progress in the program, progress of goals, behaviors, skills, and treatment progress. Five youth were interviewed. All youth reported to have the opportunity to demonstrate skills during the treatment team meetings. Each of the five youth reported staff review their performance to include progress on the performance plan goals, behaviors, and treatment progress.

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

The program has a policy and procedures ensuring staff develop and implement a vocational competency development program. Three closed youth case management records were reviewed. In a review of these records, each record included a completed employment application, résumé, appropriate documents essential to obtaining employment, along with the contact information for the local Career Source office in their hometown. The program provides Type II vocational competency development which includes communication, interpersonal, and decision-making skills. The program provides employability skills to youth to prepare them to enter into today's workforce. Youth will have the opportunity to participate in career and technical education programs, which includes Business Education, Florida Ready to Work, Career Planning through Choices, SafeServe® Certification, Occupational Safety and Health

Administration (OSHA) Certification, and Cardiopulmonary Resuscitation (CPR) and First Aid Certification. According to the facility administrator and the lead educator, youth participate in employment readiness skills training which incorporates résumé writing, completing job applications, and mock interviews.

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

The program has a policy and procedures to provide for educational access. The Duval County School District provides a year-round calendar, utilizing 250 days of school. The daily educational bell schedule begins at 7:30 a.m., ends at 2:50 p.m., and includes an hour break for lunch, which meets the minimum twenty-five hours of instruction each week. Youth receive credits for the education and training received while at the program. A review of the logbook indicated there were no interruptions during the school day and the youth were moved to and from the classrooms at the scheduled school times. Three of the five interviewed youth reported there were no interruptions during school. Two of the five interviewed youth reported there were interruptions of the school day. Those respondents mentioned youth and staff were talking in the classrooms as their justification for their response.

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

The program maintains a written policy and procedures providing for a transition plan to be developed upon admission. Three closed youth case management records were reviewed. All three youth records included an individual education transition plan, beginning at admission. The records also included an Electronic Educational Exit Plan which identified the next educational placement information. All records had the documents essential to employment, with one of the three youth also obtaining a state-issued ID card. Of the other two youth, one was a DCF involved youth, with documentation his birth certificate and social security information had been requested. The other youth was from out of state and there was a letter to his parent/guardian requesting the documents needed. Neither one of those attempts, for either youth, was successful; however, there was a notation indicating Project Connect would follow up with pursuing the youth’s identification card upon the youth’s release.

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

The program has a policy and procedures to ensure the treatment team plans for the youth's successful transition to the community upon release from the program. Five active youth records were reviewed, of which one was in the transition period. Three closed case management records were also reviewed. Documentation in each of the applicable records confirmed transition conferences were conducted at least sixty days prior to the youth's release from the program. The required participants were in attendance for each transition conference. All required participants were invited to participate by telephone or in person. If participation was not possible, the members were invited to provide written input prior to the meeting. The treatment team reviewed transition activities on all performance plans, identified transitional activities, target completion dates, and identified persons responsible for completion. The treatment team leader obtained signatures of all applicable members. In each closed record, there was documentation in each record to reflect a Community Re-Entry Team (CRT) meeting invite and to show a CRT meeting was conducted prior to the youth's release along with youth and case manager participation. An invite for the CRT was not applicable for the one open record.

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

The program has a policy and procedures to address the transition and exit process. Three closed case management records were reviewed. The exit portfolio was discussed during transition in all three records. Each exit portfolio contained the transition plan, calendar with all dates/time/locations of the upcoming community appointments, educational/vocational certificates, educational records, transcripts, résumé, and sample employment application. Two of three exit portfolios did not contain a State of Florida identification card, although the case manager attempted to obtain the information from the parent/guardian. Each of the exit portfolios were verified at the exit conference and given to the youth. The exit portfolio was forwarded to the JPO in each record.

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

The program has a policy and procedures to address the transition and exit process. Three closed case management records were reviewed. Each record documented an exit conference was held at least fourteen days prior to the release date. Each exit conference was conducted after the juvenile probation officer (JPO) was notified of the release. Each record had documentation of the exit conference date, signatures, and a summary pending transition goals. Each record had documentation to show the treatment team leader, parent/guardian, education representative, therapist, JPO, youth, and other pertinent parties participated in the exit conference. Each record had documentation of the status of transition activities and finalized plans for the youth's release. The date of admission and date of release correlated with the Department's Juvenile Justice Information System (JJIS). Each exit conference was held separate from the transition and Community Re-Entry Team meetings (CRT).

Standard 3: Mental Health and Substance Abuse Services

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

The program has a written policy and procedures delineating the role of the director of clinical services. The program's director of clinical services serves as 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 indicates time to ensure appropriate coordination and implementation of mental health and substance abuse services occur in accordance with the contract. The DMHCA also provides clinical supervision to the program's therapists in a face-to-face setting on a weekly basis, review and approve comprehensive assessments, Assessments of Suicide Risk, initial treatment plans, individualized treatment plans and treatment plan reviews, and review and approve 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 program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The program has a policy and procedures for ensuring mental health and substance abuse services are provided by individuals with the correct qualifications. The program's clinical staff is in accordance with the contract and Rule 63N-1, F.A.C. Along with the designated mental health clinician authority, who is a licensed mental health counselor, the program had one licensed marriage and family therapist pursuant to Chapter 491, F.S. The marriage and family therapist and certified addiction professional resigned since the last annual compliance review. Currently, the DMHCA facilitates all substance abuse services. The DMHCA ensures all clinical staff members working under his/her 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 program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The program has one non-licensed counselor working under the supervision of the licensed mental health counselor. The non-licensed counselor has a master's degree from an accredited university in counseling. The non-licensed counselor recently hired and had been with the program for less than one month at the time of the annual compliance review. Based on a review of documentation, 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, which includes all information of the Department's MHSA 019, the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log. The non-licensed mental health clinical staff, due to just being hired, has yet to complete twenty-four hours training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services.

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. The procedures state all youth will be administered an Assessment of Suicide Risk (ASR) within twenty-four hours of admission to the program. Five youth records were reviewed. All five reviewed records had an ASR completed with twenty-four hours of admission. Each youth record also contained a completed Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). The five reviewed records required further referrals for substance abuse services, which were documented. The facility administrator's written interview indicated the administrator's knowledge of the requirements for youth at risk for mental health and/or substance abuse problems and suicide.

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 youth records indicated each of the youth had a new comprehensive mental health and substance abuse evaluation completed within thirty days of admission. Four comprehensive evaluations were completed by a licensed professional. The remaining comprehensive evaluation was completed by a non-licensed mental health clinical staff and reviewed and signed by the designated mental health clinician authority, a licensed mental health professional, within ten calendar days of completion. Each of the five new comprehensive

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 youth was 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. 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. The program provides Substance Abuse Treatment Overlay Services (SAOS), which was documented in each of the five youth records reviewed. The five records had documentation indicating each youth participated in weekly individual therapy, daily group counseling, and monthly 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, 2020. Each of the five youth records had a valid Authority for Evaluation and Treatment (AET) form and a signed substance abuse consent and release forms. All five youth records had mental health and substance abuse treatment notes, documented on a form which contained all the information on the Department's form MHSA 018, the Counseling/Therapy Progress Notes. 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 reviewed 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. According to five direct care staff members who were interviewed, 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 who received mental health and substance abuse services. 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 included all elements of Department form MHSA 015, the Initial Mental Health/Substance Abuse Treatment Plan. Two of the five youth were on psychotropic medications. The two were on psychotropic medications upon admission to the program. All five records documented the initial mental health and substance abuse treatment plans were developed within seven days of the initial psychiatric diagnostic interview. Three of the five initial treatment plans were completed by a licensed mental health clinical staff. Two initial treatment plans were completed by a non-licensed counselor and were reviewed and signed by the designated mental health clinician authority, a licensed mental health counselor (LMHC), within ten days of completion. All five initial treatment plans were signed by all treatment team members who participated in the development of the plan. Two of the five youth records required psychiatric services to address the youth’s psychiatric needs; each identified the youth’s medication and frequency of medication monitoring by the psychiatrist.

All five of the youth records contained initial treatment plan, which included all information required from Department form MHSA 015. Three of the five plans were completed by a licensed staff. The remaining two plans were completed by a non-licensed staff and reviewed by a licensed staff within twenty-four hours. All plans were signed by all required parties. 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 admission to the program. Each of the individualized treatment plans were developed on a program form, which contained all the elements of Department form MHSA 016. Two of the five youth individualized treatment plans were completed by a non-licensed mental health staff. The two plans were reviewed and signed by the licensed supervisor within ten days of completion. The remaining individualized treatment plans were completed by a LMHC. Each of the five individualized treatment plans were signed by treatment team members, the youth, and parent/guardian.

Two of the five individualized treatment plans required psychiatric services, and each identified psychotropic medication(s) the youth were taking and the frequency of medication 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, to include 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, the Mental Health/Substance Abuse Treatment Discharge Summary. None of the three reviewed youth records 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 Treatment Overlay Services (SAOS) for each youth admitted to the program. The services include drug screening, urinalysis drug testing, individual, group, and family therapy; and 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, 2020. The designated mental health clinician authority, a licensed mental health counselor and a qualified substance abuse professional staff, is on-site at minimum of forty hours a week. Each counselor has a caseload no more than twelve youth for SAOS treatment services; however, at the time of the annual compliance review, there was a vacancy for one therapist. According to the written interview, the facility administrator revealed 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. ****Tele-psychiatry is not currently approved for use in Residential Programs****	

The program's psychiatric services are provided by licensed psychiatrist with experience in pediatrics and child/adolescent psychiatry. The psychiatrist is certified by the American Board of Psychiatry and Neurology. The psychiatrist's license was verified through the Florida Department of Health, Division of Quality Assurance as clear and active through January 31, 2022. A review of sign-in sheets confirmed the psychiatrist was on-site as required by contract. Two of the five reviewed youth records indicated the youth entered the program on psychotropic medications. The remaining youth were not on or prescribed psychotropic medications after admission to the program. One additional youth record was reviewed for psychiatric services. Each of the three 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, no changes to the youth's psychotropic medication regimen occurred, though the psychiatrist still utilized page three of the CPPN to document the psychiatric interview findings and recommendations. All three youth entered the program on psychotropic medication and had a complete psychiatric evaluation within thirty days of intake. The psychiatric evaluation had all the elements specified in Rule 63N-1, F.A.C. All youth on psychotropic medication received a review by the psychiatrist every thirty days. Each of the psychotropic medications reviews were documented on the CPPN. 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's policy and procedures include a suicide prevention plan, which was reviewed and signed by the designated mental health clinician authority (DMHCA) and facility administrator on July 15, 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 processes. 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 and training plan. The training includes 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's review process to determine if a serious suicide attempt or serious self-inflicted injury, and a mortality review require for a completed suicide 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 five records required additional suicide prevention services, and the program reported no other youth required suicide prevention services in the last twelve months. The program's policy and procedures require an Assessment of Suicide Risk (ASR) to be completed, utilizing the Department's Assessment of Suicide Risk form (MHSA 004) for each youth upon admission. The one applicable youth record was 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 – Second Version (MAYSI-2). The youth was placed on suicide precautions and the process was documented in the Department's Juvenile Justice Information System (JJIS) as an alert. A licensed mental health staff completed an ASR for the youth at admission. Notifications from the shift supervisor were completed. The youth required a follow-up ASR prior to removal from precautionary observation. The follow-up ASR included all the required elements. The youth was stepped down to close supervision. The youth was discontinued from close supervision and this action documented in accordance with the program's suicide prevention plan. 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 Suicide Precautions Observation Log (MHSA 006) to document a youth placed on precautionary observation. Five youth records were reviewed for implementation of suicide precaution observation logs. The program had only one youth placed on precaution observation in the last twelve months. 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. A review of mental health alerts indicated the designated mental health clinician authority (DMHCA) and assistant facility administrator were notified by the shift supervisor of the warning signs, as required. The logs were reviewed and signed by the shift supervisor and mental health clinical staff. The logs had documentation for safe housing requirements. The youth placed on precautionary observation was interviewed, and said staff remained with him at all times while on precautionary observation.

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. Five pre-service and five in-service records reviewed for suicide prevention training. In eight records, all six hours of suicide prevention training was completed. Two staff did not complete

all six hours. One had only four hours of instructor led training, and the other had only the two hours of web-based training completed in the Department's Learning Management System (SkillPro). The program conducted six mock suicide drills (August 7, 2019 through February 28, 2020, 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 for back-up support. Also included was 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. All reviewed staff participated in drills, as required.

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 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 using 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 July 10, 2019 and signed by the facility administrator on July 15, 2019. The plan details the notification and alert system, the referral process to include a youth's self-referral, communication, supervision levels and requirements, documentation, and a review process.

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

The program has a 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) and by the facility administrator on July 15, 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 at 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 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. The physician's specialty training is in family practice. The DHA is on-site at least once a week, with a week defined as the seven-day period beginning on Sunday and ending on Saturday. A review of documentation for the past twenty-seven weeks was reviewed and reflected the DHA is on-site once a week. In six instances the DHA was documented on-site for one hour (12/23/19, 1/6/20, 1/22/20, 1/29/20, 2/5/20, and 2/12/20), and in one case the DHA was documented on-site for fifteen minutes (11/20/19). The contract with the DHA and True Core has the DHA scheduled once a week for two hours Sunday through Saturday, and available twenty-four hours a day seven days a week. If the DHA is on vacation or scheduled absence, coverage is arranged with another doctor of equal licensure; however the DHA would still provide the administrative duties. The DHA is responsible for communication with program staff regarding youth medical needs, acute medical concerns, emergency care, and coordination of off-site care.

The DHA was interviewed and confirmed he is on-site every week. He further described his role to include performing Comprehensive Physical Assessments upon youth admission, conducting periodic evaluations every sixty days, and review and follow all policy and procedures. 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 designated health authority (DHA) and facility administrator have signed and dated all respective treatment protocols and medical facility operating procedures (FOP). Nursing staff have signed and dated a cover page on which all medical FOPs, treatment protocols, and other procedures are listed. New policies or changes in polices are reviewed, signed, and dated by each nurse on the individual policy when changes occur between annual compliance reviews. A review of orientation documentation for new healthcare staff was conducted. All newly employed healthcare personnel received a comprehensive clinical orientation to the Department's healthcare policies and procedures, which is given by a registered nurse. Approval of treatment protocols or standing procedures were written and authorized by the DHA and were not delegated to any other person. The review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management is only performed by the program's psychiatrist. A review of the program's health-related policies, procedures, and protocols indicated they have been reviewed and approved by the appropriate provider and outline the program's healthcare services.

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 Individual Healthcare Records (IHCR) were reviewed. All records had a signed Authority for Evaluation and Treatment (AET) form stamped with the word “copy” in red ink. One youth turned eighteen years old after he was admitted to the program and a form for release of information was completed. Copies of completed parental notifications were maintained behind the AET form in all five IHCRs. The AET form is printed from the Department’s Juvenile Justice Information System (JJIS) prior to admission. If an updated AET is needed, the juvenile probation officer (JPO) is contacted.

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

Five records were reviewed. Three records were applicable for and contained documentation of parental notifications for over-the-counter medications beyond those covered by the Authority for Evaluation and Treatment (AET) form. Additionally, notifications were sent, as needed, for issues such as the discontinuation of medication prescribed prior to youth entering custody, changes in conditions/medications 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 nursing 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 not listed on the AET form, for significant medication changes, and when going off-site for an appointment or an emergency. One of the five youth records had documentation indicating the youth had been off-site for medical treatment and the youth was eighteen years of age and had requested the parent/guardian not be contacted. Three of the five reviewed youth records were applicable for psychotropic medication, two of the youth had a Clinical Psychotropic Progress Note (CPPN) reflecting parent/guardian consent on page three, and the third youth was eighteen years old and did not require parental contact. All youth admitted to the program have their immunization records verified within thirty days of admission through the Florida Shots website and school records. None of the youth reviewed were applicable for refusing consent due to religious reasons.

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

The program has a written policy and procedures in place ensuring each youth will receive a screening for health concerns upon admission, or at a minimum, each time the physical custody of the youth changes and they are returned or readmitted to the program. Five Individual Healthcare Records (IHCR) were reviewed for completion of a Facility Entry Physical Health Screening (FEPHS) form. Documentation in all five records reflected a FEPHS form was completed by a registered nurse (RN) on the day of admission to the program.

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

The program has a written policy and procedures to ensure the healthcare admission screening includes health orientation education to each youth admitted to the program. Five youth Individual Healthcare Records (IHCRs) were reviewed for healthcare orientation. Documentation in each of the five IHCRs reflected the youth received healthcare services orientation on the day of admission. The program's healthcare orientation 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, what to do in the event of sexual assault or attempted sexual assault, and the non-disciplinary role of healthcare providers. A signed and dated receipt of healthcare orientation was observed in all five records reviewed.

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

The program's practice is to notify the designated health authority (DHA) for all admissions to the program. All five reviewed records contained documentation reflecting the DHA was notified by telephone for each youth upon admission to the program. The DHA notification was documented in the chronological progress notes in the Individual Health Care Record (IHCR) in each record.

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

Five Individual Healthcare Records (IHCR) were reviewed for completion of a Health-Related History (HRH) form. In all five IHCRs reviewed, a new HRH form was completed on the day of admission by a registered nurse (RN). There was indication on the Comprehensive Physical Assessment (CPA) of the DHA reviewing the HRH form. All five HRH forms were completed prior to the CPAs.

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

The designated health authority (DHA) completes a new Comprehensive Physical Assessment (CPA) for each youth within seven days of admission and annually thereafter. The program uses the Department's CPA form. A review of five Individual Healthcare Records (IHCR) found a new CPA was completed within seven days of admission for all five youth. The DHA completed each CPA and the medical grade was documented. Two youth were medical grade one, two youth were a medical grade five, and one youth was a medical grade two. Each CPA was completed in accordance with Department requirements. All sections of the CPA were marked with an "O" or an "X." Those sections marked with an "X" reflected comments by the

DHA in the comments section of the form. The Department's Problem List was updated for the four applicable youth. All five youth had at least one verified tuberculin skin test (TST) completed and documented within the last year. Each youth was assessed prior to being placed in the general population. Results of the TST were documented on the CPA and infectious communicable disease (ICD) forms in all five records reviewed. The written policy and procedures follow the Centers for Disease Control and Prevention new 2006 recommendation and Occupational Safety and Health Administration standards.

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

A review of five Individual Healthcare Records (IHCR) indicated each youth was screened and evaluated for sexually transmitted infections (STI). Documentation reflected all youth received a STI screening upon admission to the program. Testing, screening, results, clinical evaluation, and diagnosis were documented on the Infectious and Communicable Disease (ICD) form. None of the five youth reviewed were out of the Department's custody, thus none required a re-screen. Referrals for testing were documented on the STI screening form and in the progress notes upon admission. Documentation in all five youth reviewed records reflected youth were offered human immunodeficiency virus (HIV) testing, counseling, and treatment upon admission to the program. All five of the youth refused the HIV testing. A copy of the River Region's 500/501 certification was available for review. Four of five youth interviewed reported they could ask for an HIV test.

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

During the annual compliance review period, there were no youth who presented a similar sick call complaint three or more times within a two-week period. The program does have a written policy and procedures in place which provides youth with the opportunity to voice healthcare concerns and be evaluated by a nurse to determine the severity of their concerns. None of the five reviewed youth Individual Healthcare Records (IHCR) indicated the youth presented with complaints in which medical staff were unfamiliar with. Completed sick call request forms were observed filed with the corresponding progress note for one applicable youth, in reverse chronological order. Sick call was completed by a registered nurse (RN). The program does not utilize restricted housing. The program conducts sick call twice a day, as contractually required, from 12:00 p.m. to 12:30 p.m. and 3:00 p.m. to 5:00 p.m. Sick call times were observed posted throughout the program. In the event a nurse is not on-site to conduct sick call, the shift supervisor will review sick call requests within two hours and contact the designated health authority (DHA), if determined urgent in need. Progress notes were documented in accordance with Health Services Rule 63M-2. Sick calls were documented on individual youth Sick Call Indexes in the IHCR as well as the Sick Call Referral log. Sick call forms were observed to be available to youth throughout the program. One sick call was observed during the annual compliance review. The reviewer obtained the youth's permission to observe the sick call. The youth was escorted to medical by a Protective Active Response (PAR) certified staff member.

The nurse identified herself/himself and stated why the youth was there. The youth signed to indicate he was seen. The youth was seen in a private area, and proper equipment was present. All five interviewed youth advised they are seen immediately by the nurse if a sick call request is made.

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

Five youth Individual Healthcare Records (IHCRs) were reviewed for episodic care. Three of the five youth IHCRs were applicable for episodic care. One youth was referred for off-site care. Progress notes contained all required elements, including referral needed, parental notification, and plans for follow-up/future care. On-site care provided by licensed healthcare staff was documented in the subjective, objective, assessment, and place (SOAP) format. The episodic care log documents all instances of first aid/emergency care. Logs for the previous six months corresponded with all on/off-site events observed in youth records. Emergency medical and dental care, including EMS services, are available twenty-four hours a day. The program has ten first aid kits. First aid kits are located in master control, kitchen, maintenance, medical, both classrooms, the escape bag, and there is one for each vehicle. Three first aid kits were checked, and all were fully stocked with the designated health authority DHA approved items. A review of documentation indicated first aid kits are inspected weekly by a registered nurse (RN), as indicated by first aid inspection forms. The program has three suicide response kits, one located in master control and one in each classroom. All suicide response kits contained the appropriate items (knife for life, wire cutters, and needle nose pliers). The program has one automated external defibrillator (AED), which is located in the main administrative hallway. Instructions are located inside the AED. The batteries expire in April 2023, and the pads expire September 2020. The registered nurse (RN) performed a self-test during the annual compliance review, which found AED to be operational. A review of drill documentation reflected the program has conducted drills monthly and on each shift as required. Additionally, drills included the use of cardiopulmonary resuscitation (CPR)/AED or the administration of first aid quarterly, also on each shift. The program has a list of emergency numbers, including Poison Control Information Center, which are inaccessible to youth. The program has an approved list of non-licensed healthcare staff who can assist youth with medication administration or use of an epi-pen. A review of training records for these staff indicated they have completed the required training. Five of five interviewed staff advised they can call 9-1-1 if a youth has a medical emergency.

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

One of five Individual Healthcare Records (IHCR) reviewed was applicable for non-emergent off-site services. An additional two records were reviewed for off-site services. Of the three IHCRs reviewed, each contained documentation of verbal and written parental notification for off-site care. All three of the IHCRs included the completion of the Summary of Off-Site Care form. Discharge documents and instructions were in the three records reviewed. The designated health authority's (DHA) signature was observed on all three Summary of Off-Site Care forms. Two of the three youth required follow-up appointments. Appointments are tracked

by medical staff using an excel medical tracking sheet and a white board in the medical clinic dedicated to youth, as well as transport logs, which are filed within the appointment calendar.

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

Three of the five Individual Healthcare Records (IHCRs) were applicable for chronic conditions. All three IHCRs reviewed were identified as having a chronic condition on the Facility Entry Physical Health Screening (FEPHS) form. None of the three youth reviewed had a communicable disease. Two of three youth were taking prescribed medication on an ongoing basis. All three of the youth were identified as having a chronic illness on the program's internal alert roster. The chronic conditions roster includes the due dates for each youth's next periodic evaluation. Documentation reflected all three-youth received periodic evaluations every sixty days and there were no instances of lapses in care or missed periodic evaluations. All periodic evaluations were conducted on-site. The Department's Problem List for each youth was updated in accordance with the Health Service Rule 63-M. Evaluations are conducted prior to the renewal of a prescription medication about to expire. Treatment orders were observed to be written clearly for clinical staff. The facility administrator advised alerts are shared daily during management meetings and are posted in master control and dietary alerts are posted in the kitchen. The DHA advised medical uses a tracker for periodic evaluations and it is updated daily.

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

Three of the five reviewed youth Individual Healthcare Records (IHCR) were for youth taking prescribed medication upon entry to the program. Prescription verification for youth taking medication upon entry to the program was documented in the chronological progress notes in the records. Documentation reflected the registered nurse (RN) contacted the designated health authority (DHA) and psychiatrist to resume the medications. All medications were observed to have a current, valid order and were given pursuant to a current prescription. Each of the five youth were applicable for over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET). The OTC medications were administered in accordance with approved protocols. The program utilizes a pre-printed pharmacy Medication Administration Record (MAR). Documentation reflected both staff and youth initial each administered medication. There were no undocumented explanations for lapses or errors in medication administration. Nursing staff document weekly side effect monitoring on the MAR. The Six Rights of Medication Administration are maintained by both licensed and non-licensed staff. There were no instances of refusals.

All medications were observed to be stored in separate, secure areas inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stock items are kept separate from specific youth medications. Expired medication is destroyed using Medication Disposal

Container once a month according to the agreement with the pharmacist. Medication pass was able to be observed during the annual compliance review with no issues noted. All five interviewed youth reported the nurse gives out medication.

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

The program has a written policy and procedures in place ensuring the appropriate storage of all medication and equipment classified as sharps. Medical equipment classified as sharps were securely stored and inventoried by using a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Medications such as injectables, topicals, drops, and liquids were separated. All controlled substances were observed maintained behind two locks, stored separately from other medications, and had a perpetual inventory. Pursuant to the Board of Pharmacy regulatory requirements, a shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record. The program has a process in place for disposal or destruction of expired and discontinued medications. A perpetual inventory of all sharps and stock over-the-counter (OTC) medications was observed. The program maintains an approved list of supervisory level, non-healthcare staff trained in the delivery of medication self-administration in the event nursing staff is not on-site. Observations of the registered nurse (RN) inventory two youth medications, one being a narcotic/controlled medication, three OTC medications, and three sharps, all of which matched the perpetual inventory. Reporting criteria and procedures for inventory discrepancies are in place. Perpetual inventories of medications and sharps for the previous six months were available for review. According to the RN, medication inventory is done weekly and daily. The RN explained medication is destroyed via the pharmacy and a medication disposal container. The RN added, controlled medication is stored in a locked box within the secure medication cart.

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

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

director or designee will maintain a separate file containing all documents for youth and staff who have experienced facility exposure, as necessary. The program's exposure control plan was found to be written in accordance with Occupational Safety and Health Administration (OSHA) standards. The plan is available to all staff. The plan is reviewed and signed annually by the program. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. According to the facility administrator, the plan is located within the facility operating procedures, and is in a binder in master control.

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

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

Standard 5: Safety and Security

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

The program 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. Over the course of the four-day annual compliance review, observations of supervision were made each day. Staff were observed supervising youth during school hours, in the cafeteria, upon return from a youth transport, and youth movement through the facility. Staff were observed to be out of compliance with ratio requirements once in one classroom and once in the cafeteria, but met or exceeded ratio requirements at all other times. A video review of supervision during sleeping hours found the required staff-to-youth was maintained during sleeping hours. The daily schedules were posted in the dorm. The program has a full schedule of activities planned and youth were observed engaged in the activities. Staff were observed escorting youth from one location to another. At no time during the annual compliance review were youth observed wandering freely about the program. Each of the five interviewed staff confirmed their understanding of the procedures when there is a discrepancy with the count. All 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) utilized 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. Five pre-service records and five in-service records, as well as three supervisory 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 five reviewed youth case management records contained a complete orientation checklist. The BMS promotes youth rights, positive and negative consequences, constructive disciplinary action, opportunities for reinforcement, positive dialogue, and peaceful resolutions as well as provides youth with pro-social acceptable alternative behavior, maintains order and security, and minimizes the separation of youth from the population. Youth have an opportunity to explain their behavior.

The BMS is connected to each 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. 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. Three youth rated the BMS as good. Two youth rated the BMS as fair.

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 recreation therapist tallies weekly points earned by youth. At the end of each week, the point sheets are filed in each youth's case management record. 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 does not include increasing a youth's length of stay, denial of basic rights, promotion of group punishment, or disciplinary confinement. All five interviewed youth confirmed they are never punished by other youth. Positive and negative behaviors are reviewed during treatment teams. Each of the five interviewed staff indicated they received feedback on their implementation of the BMS daily and as needed. The program's BMS includes a process wherein staff explain to the youth the reason for any sanction imposed. 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 confirmed training and understanding of the BMS and indicated there are a variety of rewards 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 cameras. Twenty-three cameras were operational at the time of the annual compliance review. Work orders, budget requests, and bids have been submitted to fix the non-operational cameras. The video coverage is stored for thirty days. The program's

practice is to conduct checks of youth in their rooms every eight minutes. Video recordings and ten minute check sheets were reviewed for the dorm finding no more than ten minutes passed without the staff actively observing each youth. Five staff were interviewed; four staff indicated room checks are completed every eight minutes, and one staff stated they are completed once per shift.

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

The program's written policy and procedures address census, counts, and tracking. Observations throughout the week of the annual compliance review confirmed counts were completed in accordance with the program's policy and procedures. The program tracks daily census information including the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program in the logbook. Logbooks for the previous six months were reviewed and found no discrepancies with counts or census. Informal and formal counts were observed during the annual compliance review and found they were each conducted as required. All five interviewed staff 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.	

A review of the logbooks showed all entries were in ink, though there was evidence of eraser marks, as some entries were written in erasable ink. None of the pages were removed or obliterated. Each logbook covers a one-month period. The logbook pages are pre-printed shift reports. The first page of each shift contained staff signatures, certifying staff reviewed both current and previous shift information. In the front of each logbook, there is a page for documenting weekly reviews of the logbooks. The logbook pages documented perimeter checks, weather alerts, Central Communications Center (CCC) reports, shift summary notes, keys, radios, drills, Prison Rape Elimination Act (PREA) checks, fire safety, scheduled and unscheduled counts, and any calls made to the Florida Abuse Hotline and CCC. Incoming staff review the previous two shifts and the review is documented in the logbook.

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. 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 Communications Center (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 annual compliance review week found personal keys were secured and staff were aware of program keys in their possession. Key control logs documented the issuance and return of keys on a consistent basis with the exception of the week prior to the review, which had issuance of keys but not always the return. 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's policy must address illegal contraband and prohibited items. *A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.* *The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.*	

The program has a 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 states any staff who is found in possession of contraband in a program will be subject to disciplinary action up to, and including, dismissal, as well as procedures regarding notification of law enforcement for items considered illegal as defined in Florida Statutes. The program defines items and materials considered contraband when found in the possession of youth, 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 were no incidences of introduction of contraband documented during the annual compliance review period.

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, after work detail, and after meals. One of five youth indicated searches occur after every movement or transition. Five of five interviewed staff reported searches are conducted before and after every movement.

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

The program has three vans; however, one van is no longer used. Both of the vans currently in use had an annual safety inspection. One van was observed to be secured when not in use. The other van was off-site with staff at training. 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.

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

The program's 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. 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 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 interviewed staff 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 program shall maintain a safe and secure physical plant, grounds, and perimeter.	

The written policy and procedures designates the physical plant manager as the person responsible for conducting the weekly safety and security audits. The weekly safety audits are kept in a binder, which was reviewed. During the annual compliance review period, there were no inspections missing. The forms documented safety and maintenance repairs needed and the date and time the repairs were completed, or due to be completed. The program has documentation of on-going efforts to fix the cameras which are not operational. All the forms were reviewed and signed by the facility administrator. The forms cover radios, cameras, keys, telephones, mechanical restraints, the generator, flashlights, fire safety equipment, alarms, ensuring no anchor points, youth rooms, recreation area, grounds, correction action needed, and corrective action completed. The 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 addressing the issuance, inventory, and control of equipment and tools. The policy classifies tools as class A and class B tools, with class A tools having sharp edges and/or considered more dangerous, and class B tools being cleaning items, such as mops and brooms. All observations during the annual compliance review week found all tools were secured when not in use. Class B tools were in secured closets. All the class B tools matched the inventory. Class A tools are in the kitchen in a locked cabinet in the food manager's office and in the maintenance area; both areas not accessible to youth. The class A tools are on shadow boards and are inventoried. The inventories 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.

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, peers, and staff. The orientation checklist addresses the use of tools and training on use of tools. Each youth record reviewed contained a completed orientation checklist. Staff were aware of the 1:5 ratio during activities and vocational training involving tool use and a 1:3 ratio for disciplinary work projects. The were no disciplinary work projects during the annual compliance review week. Youth risk assessments for off-campus activities and use of tools are maintained in a binder. The binder was reviewed, and all forms were completed according to the program's policy and procedures. Each of the five interviewed youth confirmed the youth use scrub brushes, mops and brooms. One of youth reported using a hammer and rake, and three youth reported using lawn care tools. The physical plant manager conducts training with youth prior to the use of lawn mower and string trimmer. 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 contractor 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 tool 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. The tool notice forms also addressed the following: tools checked upon arrival and departure, tool restrictions while in the facility, youth being restricted from the work area, and missing tool follow-up. Outside contractors are required to sign the notice of tool equipment instructions form.

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

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 is 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 past twelve months, in accordance with the COOP. All five youth interviewed youth indicated they know what to do in case of fire. One youth indicated fire drills are

conducted monthly. All five interviewed staff reported they participate in the following drills: weather, bomb threat, escape, fire, medical, and suicide. 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. *A residential commitment program shall establish and maintain critical identifying information and a current photograph which are easily accessible to verify a youth's identity, as needed, during his or her stay in the program.*	

The Continuity of Operations Plan (COOP) is located in master control. The plan addresses alternative housing plans approved by the applicable Department regional director/designee. 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	Failed Compliance
The program director or designee shall maintain strict control of flammable, poisonous and toxic items and materials and a complete inventory of all such items.	

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. Cleaning chemicals are located in locked closets in the kitchen and dorm. Inventories in each area were reviewed. The inventory in the maintenance shed was accurate with the exception of three items not being inventoried during the current month. The inventory in the kitchen closet was last completed in December 2019 and was not accurate. An updated inventory was completed during the annual compliance review. Staff and youth interviews confirmed the youth do not use or have access to chemicals. Safety data sheets were in each area 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 shall establish and implement cleaning schedules, a pest control system, a garbage removal system, and a facility maintenance system which shall include maintenance schedules and timely repairs based on visual and manual inspections of the facility structure, grounds, and equipment, which shall be conducted bi-weekly, monthly, quarterly, semi-annually, yearly, and every three years, as prescribed in the Preventive Maintenance Checklist (RS 123, February 2019.*	

The program 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 annual compliance review week confirmed the youth do not use or have access to the chemicals. Five youth were interviewed regarding 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 personnel, or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste, shall be responsible for disposing of hazardous items and toxic materials.	

The program'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 county's 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 way it was disposed.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has written policy and procedures to allow 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. Each of the five interviewed youth confirmed they have opportunities to contact their family by phone and mail and during visitation. The visitation schedule was posted throughout the program. Visitation is held on weekends and was not able to be observed during the annual compliance review. The visitation, telephone and correspondence logs were reviewed. The logs showed youth had contact with only approved persons. Incoming and outgoing mail is searched and recorded in the correspondence logs.

5.23 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's policy, procedures, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program's policy, procedures, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

5.25 Controlled Observation Safety Checks Release Procedures	Non-Applicable
The program shall conduct safety checks for youth on Controlled Observation. The program director or designee shall approve a release when it is determined, based on his or her behavior, the youth is no longer an imminent threat to self or others.	

The program's policy, procedures, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program's written policy and procedures were reviewed and indicated a Safety Plan will be developed with each youth within fourteen days of admission and updated every thirty days. Five youth records were reviewed for Safety Plans. Three youth records showed Safety Plans were created within fourteen days of the youth's admission to the program. In one youth record, the Safety Plan was four days late. The remaining record was not applicable due to the youth being transferred to the program and having a Safety Plan in place. For all five youth, records indicate the Safety Plans were jointly prepared by the youth, parent/guardian, and program clinical staff. The Safety Plans incorporated recommendations from previous or current clinical assessments and included trauma responsive practices. However, all five records showed the plans were not updated every thirty days. The plans are kept in a binder accessible to all staff who have contact with the youth.