STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Joann Bridges Academy

Rite of Passage, Inc.
(Contract Provider)
950 S.W. Greenvile Hills Road
Greenville, Florida 32331

Review Date(s): April 20-30, 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:

Juan Youman, Office of Program Accountability, Lead Reviewer (Standard 1 & 5)
Lauren Floyd, Office of Program Accountability, Operations Review Specialist Standard 2
Warren Garrison, Office of Program Accountability, Program Monitor, Standard 2, 3, 5
Craig Swain, Office of Program Accountability, Program Monitor, Standard 4
Lea Herring, Office of Program Accountability, Program Monitor, Youth and Staff Interviews

Program Name: Joann Bridges Academy
Provider Name: Rite of Passage, Inc.
Location: Madison County / Circuit 3
Review Date(s): April 20 - 30, 2020

MQI Program Code: 1444
Contract Number: 10361
Number of Beds: 28
Lead Reviewer Code: 141

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

Overall Rating Summary
All indicators have been rated Satisfactory and no corrective action is needed at this time.

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	Non-Applicable
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	Satisfactory

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Joann Bridges Academy is a twenty-eight-bed program, for twelve to eighteen year old females, located in Greenville, Florida. The program is operated by Rite of Passage, Inc. through a contract with the Department. The program provides mental health overlay services to all the youth in the program. In addition, the program provides youth with the following treatment strategies, Aggression Replacement Training (ART), Seeking Safety, Voices, Living in Balance, Impact of Crime, and Thinking for a Change which are all evidence based curricula. Additional treatment services provided include individual, group and family therapy. The program also offers youth recreational therapy. The program offers youth gender-specific programming, restorative justice and life skills through the following curricula Teen Relationship, Voices, Character Traits, and Girls-Trauma Recovery & Empowerment (G-TREM). Program administration is comprised of a program director, compliance manager, recreation therapist/dean of student services, human resources/administrator assistant, building manager, transitional coordinator, clinical director, registered nurse (RN), two supervisors, and sixteen coach counselors. Case management and mental health services are provided by three therapeutic managers, clinical director, and the transitional coordinator. Medical services are offered Monday through Friday from 6:30 a.m. until 4:00 p.m. and are provided by a RN and one medical doctor. Educational services are provided by the provider Rites of Passage, Inc. The layout of the program includes: one building with two youth dorms, a gymnasium, medical clinic, cafeteria, two classrooms, offices for administration and a portable with offices for the clinical director, therapeutic manager, and transitional coordinator. The program has twenty-two operating security cameras providing coverage. At the time of the annual compliance review, the program had five vacant positions; one therapeutic manager, two night coach counselors, one coach counselor, and one part-time RN. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of specific indicators or elements were unable to be completed, during this fiscal year. Off-site supplemental reviews were conducted as desk audits throughout the remainder of this fiscal year.

Strengths and Innovative Approaches

The program has a family van loop transportation which provides transportation for parent/guardians to the program for visitation. Parent/guardians are given the guidelines and as well as consequences for not following the guidelines.

Standard 1: Management Accountability

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

A review of the program's staff roster found five staff required an initial background screening. Each of the staff received a background screening completed prior to hire. Two staff required a pre-employment assessment tool which was completed, and the staff received a passing score. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Department's Background Screening Unit on January 9, 2020. There was documentation to confirm the program reviewed the Central Communications Center (CCC) person involvement history report, Staff Verification System (SVS), module, and Florida Department of Law Enforcement Automated Training Management System (FDLE ATMS) results.

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

The program has a policy and procedures requiring five-year rescreening for staff. A review of the staff roster found none of the staff required a five-year rescreening during the annual compliance review period.

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

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

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

Interviews and photos revealed the program have posting of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers throughout the facility. The program did not have any incidents related to physical, psychological, or emotional abuse during the annual compliance review period. A review of five staff records revealed they must adhere to a Code of Conduct which is signed by all employees. A review of the policy indicated if any staff or volunteer has reason to suspect a youth in the program may have been abused, this information is immediately reported to the supervisor. After verbally reporting to the supervisor, the employee provides written documentation of what was observed to the supervisor. The supervisor on duty reports to the Department's CCC within the required two-hour time frame. Five interviewed staff reported the process for allowing youth and staff to call the Florida Abuse Hotline or CCC involves notifying the supervisor, the program director, and ensuring unimpeded access to the hotline. Each youth and staff are allowed to make the call to the Florida Abuse Hotline or CCC in which the staff dials the number for the youth. Five staff reported they have never observed a co-worker denying a youth the opportunity to call the Florida Abuse Hotline. Five interviewed staff reported never observing a co-worker use profanity when speaking to a youth, using threats, intimidation, or humiliation when interacting with youth. Five interviewed youth stated they felt safe at the program and have never be stopped from reporting an abuse to the Florida Abuse Hotline or CCC since they have been at the program. Four of the five youth reported staff are respectful when talking with youth. The remaining youth stated some of the staff talk down to youth. Four youth reported they have not heard staff use profanity when speaking to youth. One youth reported hearing staff use profanity often and having a negative tone. The program director stated included in the program's code of conduct, staff are to respect and have courtesy toward youth. It promotes and exemplary law abiding behavior. Staff are to refrain from conduct which is corrupt or illegal or serves to degrade, demean, or disregard the welfare of others. The program director reported the incident reporting process includes shift supervisors or administrative staff placing calls to the CCC and

following the program's policy. At the program, all youth have unimpeded access to the Florida Abuse Hotline or CCC for youth eighteen years of age or older. The program mandates all suspected or alleged incidents of child abuse/neglect are reported as required by law. The program's policy indicated the program does not tolerate abuse/neglect. Each youth and staff are allowed to make the call to the Florida Abuse Hotline or CCC in which the staff dials the number for the youth. The shift supervisor will follow the incident reporting procedures following all abuse calls.

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 did not have any incidents of physical, psychological, or emotional abuse since the last annual compliance review. An interview with the program director revealed training is conducted with the youth and staff. The telephone numbers and reporting procedures are posted throughout the facility. All calls are logged into the Department's Central Communications Center (CCC) or Florida Abuse Hotline call log, administration is contacted immediately, and reports are completed after. The program director also stated youth are provided with a monthly survey during formal treatment team meetings. The program director revealed there were no staff having disciplinary actions due to allegations of abuse towards a youth since the last annual compliance review.

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.	

A review of the Department's Central Communications Center (CCC) reports found the program had a total of three CCC reports within the last six months. Each of the incidents were reported within the required two-hour time frame. Two of the reports which required documentation in the Logbook/Shift Report were documented. A review of the internal incidents and grievances found there were no additional incidents needing a report to the CCC. The program had not experienced an increase in the number of reportable incidents to the CCC. The program director reported the incident reporting process includes shift supervisors or administrative staff placing calls to the CCC and following the program's policy.

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.	

An interview with the program director revealed the program did not have any Protective Action Response (PAR) reports within the last six months. A review of the monthly summaries found the program had not experience an increase in the number of PAR reports since the last annual

compliance review. The program's PAR Plan was approved by the Department on February 7, 2020. The program's PAR rate during the annual compliance review period was 0.00, which is below the statewide Residential PAR rate of 2.41. The program director stated the program monitors PAR incidents and use of force daily, weekly, and monthly.

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

A review three staff training records found each staff were eligible for pre-service training. All three staff were certified within 180-days of hire. Each staff had the required essential skills completed prior to any contact with youth to include cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professional and ethics, suicide prevention/intervention, emergency procedures, Prison Rape Elimination Act (PREA), and active shooter training. The program provided the review team with documentation noting all instructors were qualified to deliver the training provided. The program submitted, in writing, a list of pre-service training to the Department's Office of Staff Development and Training which includes course names, descriptions, objectives, and training hours for any instructor-led training on January 14, 2020. The three staff also received training in the grievance process, infection control, behavior management system (BMS), and training for staff on the intended and safe use of tools. All of the pre-service training is documented in the Department's Learning Management System (SkillPro).

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

Seven staff training records were reviewed for in-service training. All seven staff had the required training to include cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professional and ethics, suicide prevention to include two-hours of SkillPro and four hours of webinar or instructor led, active shooter training, and grievance process. The program provided the review team with documentation noting all instructors were qualified to deliver the training provided. The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training which includes course names, descriptions, objectives and training hours for any instructor-led training on January 14, 2020. The program has an annual in-service training calendar, which is updated as changes occur. Two supervisor training records were reviewed and both had the required eight hours of supervisory training in management, leadership, personal accountability, employee relations, communication skills, and fiscal training. All in-service training is documented in the Department's Learning Management System (SkillPro). All licensed nursing staff have a current certification in CPR with AED.

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

The program has a policy and procedures to include the training requirements of the grievance process. A review of three pre-service and seven in-service training records found each staff had training in the grievance process. According to the program's policy, if a student believes a right has been violated, the student must attempt to rectify the situation by informally discussing the matter with the staff member. If the student is not satisfied with the outcome of the informal discussion, the student can request a grievance form from any staff member to complete and place in the grievance box. Once the grievance is received a response must be completed within seventy-two hours by the appropriate staff. If the youth is not satisfied with the decision, the youth can fill out the appeal section on the bottom of the grievance and forward the completed appeal to the designated administrator for resolution. The designated administrator must provide a written response to the appeal within seventy-two hours. Once the appeal is determined to be substantiated or unsubstantiated, the grievance form is completed and a copy is placed in the master grievance binder which the youth receives a copy. Five interviewed youth revealed they understood the grievance process. Four of the five youth reported they could ask for assistance in completing a grievance form. Five interviewed staff stated they were knowledgeable of the grievance process at the program. The program director stated the program has three grievance phases to include an informal, formal, and appeal. The program director reviews all grievances. An interview with the program director revealed the program did not have any grievances in the last twelve months.

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 implemented interventions for each youth at the program. These interventions included evidence-based practices, promising practices, or practices with demonstrated effectiveness. The program currently has five staff facilitating these interventions. Each of the staff received the proper training to facilitate the interventions. An interview with the clinical director and program director revealed the program utilizes Aggression Replacement Training (ART), Seeking Safety, Girls-Trauma Recovery & Empowerment (G-Trem), Voices, Living In Balance, Impact of Crime, and Thinking for a Change. The program director revealed staff member's education and work experience were considered when determining which staff to deliver the life skills training or groups. Sign-in sheets were reviewed for each intervention as well as the program's activity schedule and found the above named interventions are being conducted at the program . A review of five youth records found youth were involved in a delinquency intervention either evidence-based, a promising practice, or with demonstrated effectiveness. Each of the youth's performance plans addressed an identified priority need. Five interviewed youth stated they participated in delinquency intervention groups.

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

The program has a policy and procedures concerning life skills at the program. The youth at the program receive life and social skills intervention services which specifically address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking including problem-solving and decision making. The program utilizes Teen Relationship. Five interviewed youth stated they participated in life skills training at the program. A review of the sign-in sheets and activity schedule confirmed the program was providing life skills training to the youth.

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

The program has a policy and procedures concerning restorative justice awareness for youth. An interview with the program director revealed the program utilizes Impact of Crime and Voices as the curriculum for restorative justice. The program director revealed the youth are exposed to victim's perspective through victim speakers, education, volunteer, and community service projects. The program reviews the youth's risk assessment, court orders, and the behavior management system to determine if youth are permitted to participate in activities intended to restore victims and communities. The restorative justice activities were designed to assist youth to accept responsibility for harm they have caused by their past criminal actions, challenging them to recognize and modify their irresponsible thinking such as denying, minimizing, rationalizing, and blaming victims. Also providing the opportunities for youth to plan and participate in reparation activities intended to restore victims and communities, such as restitution activities and community service projects. A review of the sign-in sheets and activity schedule revealed the program was providing restorative justice activities. A review of five youth records found each youth were receiving services to increase youth accountability for criminal actions and harm to others.

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

The program design their services based on the common characteristics of the primary target population. The program utilizes Voices, Character Traits, and Girls-Trauma Recovery & Empowerment (G-TREM) for their gender-specific programming. Voices is a curriculum created to address the unique needs of adolescent girls and young women. A review of the sign-in sheets and activity schedule indicated the program was providing restorative justice activities. An interview with the program director revealed the program address the needs of a targeted gender group individually.

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 to determine how alerts are identified, documented, updated, and communicated to staff. A review of the program alerts found to be consistent with the alerts which were entered in to the Department's Juvenile Justice Information System (JJIS). There were no discrepancies noted. A review of five youth records found each of the youth were placed on an alert and later removed by the appropriate staff at the program. The program director revealed weekly and face to face meetings are held with the healthcare staff to review important medical issues pertaining to the youth at the program. The program director also stated the medical department is responsible for opening and closing alerts related to medical issues and food allergies. The therapeutic managers are responsible for opening and closing alerts related to mental health/substance abuse related issues. Five interviewed staff revealed they are informed of the youth's alerts by reviewing the alert book which is signed daily, during daily debriefings, and by medical and mental health staff.

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 has a policy and procedures concerning youth records. The program separates the youth records into three separate files by individual healthcare, mental health, and management. Due to theCOVID-19 pandemic restrictions, the program provided pictures to review the youth records as an alternative source to validate the program's practice. The file tab on the individual management record contained the youth's name, department's identification number (DJJID), date of birth, county of residence, and committing offense. These records also contained legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. Each of the youth records were found to be labeled "confidential" as well as the file cabinet used to store the youth records.

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

The program has a formal process to promote constructive input by youth. An interview with the program director confirmed the youth participate in student council and weekly question and concern sessions. Youth also make recommendations for resolutions to improve conditions and

enhance the quality of life for staff and youth in the program at the meetings. Sign-in sheets and minutes from these meetings were reviewed and found the meetings were taken place as scheduled. Five interviewed youth stated the program has a process allowing youth to provide input on what happens at the program. These include Positive Organization Culture meetings and weekly recognition groups. The program director revealed the youth also use ”Speak Out” forms as an outlet for youth to speak with members of their treatment team one on one.

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

The program has a policy and procedures in place concerning the make-up and function of a community advisory board (CAB). A review of sign-in sheets, agendas and minutes confirmed the program has a community advisory board meeting at least every ninety to 120 days. There was documentation of the program director soliciting active involvement of interested community partners including representatives from law enforcement, the judiciary community, the school board or district, the business community, the faith community, and if possible a representative from the lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI) community. There was documentation of the program director recruiting a victim, victim advocate, or other victim services community representative, and a parent/guardian whose child was previously rather than currently involved in the juvenile justice system. An interview with the program director revealed the program’s CAB consists of members of the community who are former educators, school board members, small business owners, and the parent/guardian of a former Department of Juvenile Justice involved youth. Meetings are held every quarter on the last Thursday of the month. The director revealed the function of the CAB is for recommendations on community projects or events and to solicit volunteers for the program and facility’s improvement.

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

The program has a policy and procedures in place concerning program planning and evaluation. The program provides evidence of parent/guardian and youth surveys being completed. The program developed a system of communication to keep the staff informed and allow them the opportunity to provide input and feedback pertaining to operation of the program. Staff are allowed to provide input during shift exchanges, debriefings, monthly staff meetings, and the provider’s news email. A review of minutes and agendas revealed meetings are occurring monthly and daily at shift exchange and debriefings. The program attempts to minimize staff turnover by offering referral bonuses and pay increases. The program currently have five vacancies in which they are attempting to fill. The program director revealed staff are kept informed of important development or changes within the program through daily shift exchange and monthly staff meetings. Five interviewed staff revealed staff meetings are held monthly and daily. Staff interview revealed topics discussed during the meetings are related to the safety and security of youth, ways to improve the program and staff improvements, Prison Rape Elimination Act (PREA), COVID-19 pandemic, any recommendations, concerns issues, any changes to the behavior management system, or relevant events during the work day. All five staff reported the meetings are valuable and informative. Each staff reported they are briefed on annual reports and parent/guardian survey results. Two staff stated communication among the staff is very good, two stated good, and one stated fair. Five staff reported they are able to

provide input and feedback into the program's operations during staff meetings and anytime at the staff's discretion. The program director stated the outcome of the data used by the program are from Rite of Passage key performance indicators which are completed monthly, surveys, and CAR report.

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

The program's policy and procedures to determine the program's system for evaluating staff, performance standards, and frequency of evaluation was reviewed. All program staff job descriptions were reviewed and each staff' member's performance standards were identified. A review of the performance evaluations for each job description revealed they were completed. The program director revealed staff are evaluated within the first ninety days of employment and annually thereafter. Three of the five interviewed staff stated they receive formal evaluations on their performance based on their performance standards, yearly. The remaining two staff stated every six months.

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

The program has a policy and procedures in place concerning recreation and leisure activities. The program's policy and procedures provide activities based on the developmental levels and needs of the youth in the program. A review of the activity schedule revealed the program provides a variety of recreation and leisure activities. The activities includes a choice of leisure and recreation options. Youth are encouraged to explore interests which are identified on their performance plans and youth goal proposals. Youth are engaged in constructive use of leisure time through watching television, letter writing, team sports, board games, study hall, puzzles, and arts & crafts. The program also offers activities to promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The youth are involved in dodgeball, volleyball, yoga, Zumba, inside softball, basketball, and kickball. The program's contract requires a recreational therapist. A review of the credentials, schedules, and services provided to youth ensured all requirements were met. Five interviewed youth stated they are provided with physical activities and leisure activities at least one hour each day to include volley, softball, basketball, dodgeball, kickball for recreation. Board games, puzzles, discussions, and coloring for leisure. Five interviewed youth reported they are provided varying degrees of mental and physical exertion throughout the day. One interviewed staff revealed youth participate in both indoor and outdoor activities for a period of thirty minutes to an hour each day. One staff reported recreation time is one hour and leisure time is about forty-five minutes. A third staff reported outdoor recreation is one hour. The remaining two staff did not report a specific time but listed the different activities the youth participated in. Staff reported the youth participate in different sports as well as games from the game cabinet, and team building activities.

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 ensuring each youth's parent/guardian is notified by telephone within twenty-four hours, as well as in writing within forty-eight hours upon the youth's admission to the program. A review of five youth records found each youth's parent/guardian was notified by telephone and in writing within the required time frames. The program also has a policy and procedures regarding the notification of the youth's committing court, juvenile probation officer (JPO), and post-residential services counselor (if applicable) within five calendar days of the youth's admission to the program. All of the records contained documentation indicating the committing courts, JPOs, and post-residential services counselors were each notified, as required.

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

The program has a policy and procedures regarding the provision of an orientation to each youth within twenty-four hours of admission to the program. A review of five youth records determined each youth received an orientation to the program which occurred the day the youth was admitted to the program. Each of the youth initialed next to each topic listed on the orientation checklist, indicating the topics were reviewed with them. All required topics were included on the orientation checklist. All five interviewed youth reported orientation to the program began within twenty-four hours of their admission to the program. Each youth also reported orientation included the program's rules, procedures, and schedules.

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 obtain the 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 screenings, assessments, or treatment. None of the five reviewed records were applicable for a youth eighteen years of age or older; therefore, the program provided only two applicable records from the annual compliance review period for review. A review of both applicable records found each contained a signed Eighteen Year Old Authorization for Release/Request for Information form by the youth, as required.

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

The program has a policy and procedures in place to classify each youth within twenty-four hours of admission to determine the most appropriate placement, sleeping arrangement, and level of control throughout the youth's stay at the program. All five reviewed youth records had documentation indicating the youth received an initial classification the same day the youth were admitted to the program. A review of the classification forms determined the forms contained all the required elements. Each classification form also included a review of each youth's possible risks including suicide, mental health, medical, and escape risks. Four of the five youth were identified as security risks and one youth was also identified with a suicide risk. Each of the applicable alerts were entered into the Department's Juvenile Justice Information System (JJIS), as required. A new Victimization and Sexually Aggressive Behavior (VSAB) form was completed for each youth prior to receiving a room assignment; however, the VSABs were completed by hand or typed and not entered into JJIS, as required by FDJJ 1919. During the annual compliance review, the program put in a work order with the Department's data integrity officer to obtain access in JJIS to enter these assessments and correct this issue.

The program also has a policy and procedures to reclassify youth based on new information gained, based on the youth's needs, safety, and security. The reclassification may lead to the youth being assigned to a new room, living area, group, or program. Reassessing youth must also be completed prior to the youth participating in any off-site activities, increasing a youth's privileges and freedom of movement, or work projects which may involve tools or other items which may be used as weapons or means of escape. All five reviewed youth records reflected the youth received a reassessment prior to increasing the youth's privileges or freedom of movement. Four of the five youth received a reassessment prior to participation in work projects using tools or off-site activities. An interview with the program director revealed the program uses a classification form which takes into consideration the youth's mental health status, physical status, cognitive performance, age, and prior victimization when assigning 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 related to youth gang identification and notification of law enforcement. Each newly admitted youth is screened to determine if the youth has any gang association. The program director (PD) or designee actively participates with local law enforcement agencies and/or other criminal justice agencies including the Department, Department of Corrections, Florida Department of Law Enforcement, and other appropriate law enforcement knowledgeable of criminal street gangs to coordinate sharing of information for

Florida's Gang Intelligence System. A review of five youth records found each of the records contained a screening to determine if the youth had any gang association; however, none of the youth had any gang affiliations. A review of the Department's Juvenile Justice Information System alerts and internal alerts found none of the youth had gang alerts or gang affiliation. The program reported none of the youth in the program had any gang affiliations during the annual compliance review period.

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.	

None of the five youth records reviewed were applicable for gang affiliation. The program reported none of the youth during the annual compliance review period had any gang association. All youth have a gang questionnaire completed upon admission and a letter is sent to the youth's parent/guardian which includes a brochure regarding gang court with the Department. The program also utilizes the ARISE curriculum as part of the gang prevention/awareness efforts provided at the program. A review of sign-in sheets determined groups were delivered, as designed.

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.	

A review of five youth records found each youth had a Residential Assessment for Youth (RAY) completed within thirty days of admission, as required. Each of the RAY assessments were entered into the Department's Juvenile Justice Information System (JJIS). Three of the five youth records were applicable for RAY Reassessments. The remaining two youth had not been in the program long enough to receive a reassessment. There were a total of seven RAY Reassessments completed for the three applicable records. Two of the seven reassessments were completed within ninety days of the initial RAY assessment, as required. The remaining five reassessments were completed between one and four days late. The noted exceptions were limited in scope and did not impact the overall care, custody or service delivery provided to the youth. The program maintained all RAY Reassessment documentation in each applicable youth's record.

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

The program has a policy and procedures ensuring a Youth Needs Assessment Summary (YNAS) is completed within twenty-one days of admission; however, Department Rule requires

the YNAS to be completed within thirty days of admission. Three of the five youth records reflected the youth had a YNAS completed within twenty-one days of admission, as required by program policy. The remaining two YNASs were completed six and eight days late. However, all of the assessments were completed within thirty days, as required by Department Rule. 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 regarding performance plan development, goals, and transmittal. A review of five youth records determined each youth had an individualized performance plan developed within thirty days of the youth's admission to the program. Each of the performance plans were developed after the initial assessments. All of the records documented the youth, treatment team leader, representatives from administration and living unit, treatment staff, education, and Department of Children and Families (DCF) (when applicable) were present during the development of the youth's performance plans. Each of the plans were signed by the youth treatment team leader and all other pertinent parties with significant responsibilities in goal completion. All five records contained documentation indicating the parent/guardian were sent a copy of the performance plans with a signature sheet to return to the program; however, only one was returned to the program.

A review of all five performance plans found each plan contained individualized goals based upon the prioritized needs of the youth identified during the initial assessment process. Each of the youth's top three criminogenic needs were addressed on the performance plans. Four of the five performance plans also included a delinquency intervention. All five plans included target court-ordered sanctions, transition activities, youth and staff responsibilities, and target dates for goal completion. Within ten working days of the performance plans being completed, a copy of the plans and transmittal letters were sent to the youth's committing court, juvenile probation officer, and DCF (if applicable). Copies of the plans and transmittal letters were also sent to the youth's parent/guardian; however, one letter was dated June 12, 2020 for a performance plan developed July 9, 2020. Follow-up with the program found this was a typo. All five interviewed youth reported they received a copy of their performance plans.

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

The program has a policy and procedures regarding performance plan revisions. Performance plans are revised when determined necessary by the intervention and treatment team. Three of the five youth were applicable for performance plan revisions. Each of the three applicable youth had performance plan revisions due to Residential Assessment for Youth (RAY) Reassessment results. One youth had revisions based on newly acquired/revealed information, one youth had revisions due to demonstrated progress towards completing goals, and two of the youth had revisions due to lack of progress toward completing goals. One youth also had a revision to their performance plan to facilitate transition activities during the last sixty days of the youth's stay at the program.

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

A review of the program's policy delineates the program initiative to prepare a summary of the youth's performance. The therapeutic mangers complete a performance summary every ninety days following the development of the performance plan for each youth. The performance summary serves as a vehicle to inform all pertinent parties of the youth's overall adjustment and performance in the program. Procedures include a performance summary on each youth every ninety days after the development of the initial performance plan and distribution of the performance plan to the committing judge, juvenile probation officer (JPO), conditional release provider, Department of Children and Family (DCF), parent/guardian, along with a transmittal letter within seven days. The performance plan addresses, but not limited to, the youth's status, such as behavior, academics, initial adjustment, willingness, interaction to peers, mental health, medical, and release, discharge, or transfers if applicable.

Five youth case management records were reviewed. Each performance summary included the required information. Three closed youth case management records were reviewed and each had the required information. Each performance summary had a youth's comment section designated for the youth before signing. The therapeutic manager who prepared the performance summary, the treatment team, the program director, and youth reviewed, signed, and dated the summary. The program forwarded the original signed Performance Summary together with the Pre-Release Notification and Acknowledgement form to the youth's JPO of the three closed youth case management records reviewed. The program filed the original, signed Performance Summary in the official youth's case management records. All summaries were complete in the proper time frame.

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 regarding parent/guardian involvement in case management services. Five reviewed youth records contained documentation indicating the program encouraged parental involvement in the assessment process, development of the youth's performance plan, progress reviews, formal treatment team reviews, and transition planning. Upon admission, each parent/guardian was mailed a letter and brochure detailing the program's services and procedures, as well as the date and time of the youth's first treatment team meeting. If unable to attend any of the meetings in person, the program allowed for the parent/guardian to participate by telephone, video conference, or to provide verbal or written input prior to the meeting. An interview with the program director revealed invitation letters and telephone/video calls are utilized to encourage parent/guardian participation. All five interviewed youth reported their parent/guardians are involved in the case management process.

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

The program has a policy and procedures regarding the members of treatment team. A review of treatment team meeting documentation found sign-in sheets documented signatures from the youth, treatment team leader, parent/guardian, juvenile probation officer, and Department of Children and Families (if applicable). Signatures from the program director (PD) or designee, living unit, education, and medical services were not included on the sign-in sheets. Each program area including the living unit, education, medical, and clinical all provided written input. Although the written input provided was detailed and thoughtful, the input was at times, dated prior to the day of the treatment team meetings. The PD's signature was also dated days to weeks after the day of the treatment team meetings. Follow-up with the recreational therapist (RT)/director of student services revealed the RT represented the administration, supervisors represented the living unit, and either the RT, supervisors, or clinical director represented medical during treatment team meetings. It was further reported all program areas were in attendance during the meetings other than the PD and medical. A review of the program's chronological notes for each youth revealed all department areas were involved in the treatment team meetings.

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 ensuring each youth's performance plan reference or incorporates any other treatment or care plans, as applicable. A review of five youth case management records found each youth's performance plan incorporated the youth's academic and treatment plans. None of the youth were applicable for a DCF case plan or Agency for Persons with Disabilities 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 ensuring formal treatment team meetings are held every thirty days for each youth. Policy and procedures also require informal treatment team meetings to be held bi-weekly each month. A review of five youth case management records determined formal and informal treatment team meetings were held, as required. Documentation for each formal and informal treatment team meeting included the youth's name, date of review, comments from each program area including the living unit, education, medical, and clinical, a synopsis of the youth's progress, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting physical interventions, treatment progress, and Residential Assessment for Youth (RAY) Reassessment results. All five interviewed youth reported staff reviewed their performance including their progress on performance plan goals, positive and negative behaviors, and treatment progress. The youth also reported they are given the opportunity during treatment team meetings to demonstrate any skills they have learned in the program.

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

According to the program's policy the academic curriculum for the education program is designed to provide educational services based on the youth's needs. Procedures include instructions delivered by the teachers based on assessments of the student's needs. The program utilizes a contract with Madison County School District offering a curricular based on the school district's Pupil Progression Plan and the current Florida Course Code Directory and Instructional Personnel Assignments. Teachers incorporate the Florida Sunshine State Standards guidelines into the classroom's instructions. The program follows the Madison County Public Schools Exceptional Student Education Special Programs and Procedures manual for identifying students with disabilities. Curriculum offering will match the cultural diversity at the program. Students will be provided 300 minutes of instructions for each student daily.

Five closed youth case management records were reviewed. Type two programing was provided to each youth reviewed. Career education included all the required programming. Each youth had a sample employment application, résumé, Career Source Center information, Department of Highway Safety and Motor Vehicles state-issued identification cards, and documentation the youth's parent/guardian and juvenile probation officer (JPO) are aware of the youth's vocational plan. An interview with the program's facilitator revealed each youth received a SAFE- SERV certification, a certificate for a Nursing Assistant, and Microsoft's programming certificate, as documentation provide by the program was made available for review. The lead teacher reported all youth are identified with employability as one of their goals at the time of release from the program.

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.	

According to the program's policy, the program provides lesson plans, materials, and activities. Instructions in reading, writing, language arts, and math is provided. The Madison County School District provides approved tutorials, remedial, and literacy instructions including the Florida Sunshine State Standards (FSSS) and the Florida Course Code Directory and Instructional Personnel Assignments.

Five youth case management records were reviewed. Each youth record determined each youth was enrolled in an educational program and was earning course credits. The program's daily schedule was provided and it contained 250 days of educational instructions. Logbooks determined minimal interference of education instruction and education classes were taking place as scheduled. Five youth were interviewed. Two youth reported class is interrupted for bathroom breaks or groups and three youth reported there were no interruptions.

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

Three closed youth case management records were reviewed. Each youth had an individual education transition plan developed which was based on the youth's post-release goals, beginning at admission. All of the plans identified the youth, parent/guardian, Department personnel, instructional personnel from the program, and school counselor as key participants related to transition activities. Each of the plans were developed with the youth and program, education, and aftercare staff, with specific plans for continuation of education and/or employment. A review of the education transition plans determined each plan addressed all required elements. All three records also documented the youths' case managers and parent/guardians were aware of the plans, documents, and post-release discharge plans.

Each record contained a sample of completed employment applications, résumé, and documentation indicating the location and business hours of a local Career Source Center, as well as documentation indicating the youth's parent/guardian and juvenile probation officer were aware of the youth's vocational plans. Two of the three records contained a state-issued identification card. The remaining youth's parent/guardian refused to provide the information to obtain an identification card. None of the records contained a copy of the youths' birth certificates or Social Security cards.

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

The program has a policy and procedures addressing transition planning and conference, as well as the Community Re-Entry Team (CRT) meetings. A review of three closed youth case management records determined each youth's transition conference was held at least sixty days prior to the youth's anticipated release date. Documentation indicated the youth, treatment team leader, program director or designee, and other required team members participated in each transition conference. Each record also documented the youth's juvenile probation officer (JPO), parent/guardian, education, and other pertinent parties were invited and encouraged to participate in the conference meeting.

Documentation from each transition conference indicated participants reviewed the transition activities included on the youth's performance plan, revised the youth's performance plan (if necessary), and identified transition activities, target dates, and individuals responsible for completion. Transition conference documentation also included dated signatures from each of the participants. Each of the records contained documentation indicating a copy of the plan was sent with a request to return with signature to anyone not in attendance at the meeting.

All three records documented a CRT meeting was held prior to the youth's release from the program. Documentation in each of the records indicated both the youth and therapeutic manager participated in the CRT meeting, as required. All records also contained evidence of an invitation to participate in the CRT meeting.

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

Three closed youth case management records were reviewed. Each record had documentation indicating the exit portfolio was discussed and initiated during the transition conference. Each record contained a sample of completed employment applications, a résumé, documentation indicating the location and business hours of a local Career Source Center, educational and/or vocational certificates earned, educational records, and school transcripts. Two of the three records contained a state-issued identification card. The remaining youth's parent/guardian refused to provide the information to obtain an identification card. None of the records contained a copy of the youths' birth certificates or Social Security cards. All three records documented the

exit portfolios were verified during the exit conference, the portfolios were given to the youth upon release from the program, and the program forwarded the portfolio information to the youth's juvenile probation officer.

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 addressing exit conferences. Three closed youth case management records were reviewed for exit conferences. Reviewed documentation indicated the exit conferences were conducted after the program notified the youth's juvenile probation officer (JPO) of the youth's pending release and at least fourteen days prior to the youth's release date. The exit conference documentation in each of the records documented the date, signatures or names, if participating by telephone, and a summary of pending transition goals. A review of the Department's Juvenile Justice Information System (JJIS) found the admission and termination dates correlated with those documented in each youth's record. All three records documented a review of the status of the youth's transition activities established at the transition conference and finalized plans for the youth's release. Each of the three records documented the youth, education representative, JPO, and other pertinent parties participated in the exit conference. Two of the three records documented the youth's parent/guardian participated in the exit conference. All records documented the exit conference was conducted separately from the transition and Community Re-Entry Team meetings.

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's policy which was developed by the program's director, makes provisions for administrative oversight and management of mental health and substance abuse services. The program provides behavior health overlay services (BHOS) and mental health overlay services (MHOS). The program has a single licensed mental health professional designated as the designated mental health clinician authority (DMHCA). The DMHCA is responsible for coordination and implementation of mental health and substance abuse services.

The DMHCA is a licensed mental health counselor under Chapter 491. Upon review, the DMHCA's license expires on March 31, 2021. According to a review of the sign-in sheets, the DMHCA is on site weekly for eight hours a day, five days a week or more as required by the contract. Sign-in logs determined the DMHCA was on-site enough time to provide appropriate services and to implement mental and substance abuse services. The DMHCA reported the role of the DMHCA is to provide direct supervision of all mental health and substance abuse education and to ensure all clinical documentation is reviewed and is appropriately completed.

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

The program does not have any other licensed clinical staff other than the designated mental health clinician authority; therefore, this indicator rates as non-applicable.

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

The program's policy which was developed by the program director, addressed mental health and substance abuse services are provided by individuals with appropriate qualifications.

A review of the staff roster determined staffing was in accordance with the contract. The program utilizes three non-licensed clinical staff. A review of educational and training requirements for the non-licensed clinical staff determined each of the three staff have the appropriate trainings and education. One of the three non-licensed staff holds a master's-level degree from an accredited university or college in the field of social work. The remaining two non-licensed staff have bachelor's-level degrees and two years of clinical experience assessing, counseling, and treating youth with serious emotional disturbance or substance abuse problems. Each non-licensed mental health clinical staff had twenty hours of training and supervised experience in assessing suicide risks and because each staff provides substance abuse services, each staff reviewed had training in accordance with the Rule.

The DMHCA maintains a supervision log with at least one hour a week of on-site face to face interactions with the non-licensed mental health professionals. The purpose of the DMHCA's direct supervision is to provide oversight, as defined in Section 397.311. The direct supervision was recorded on the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log, form MHSA 019. The DMHCA is also responsible for reviewing the Assessment of Suicide Risks, crisis assessments, and follow-up crisis assessments. The DMHCA must sign each assessment.

The facility is licensed under Chapter 397. The license expires on March 23, 2021. Each non-licensed staff had documentation of being directly supervised by the designated mental health clinician authority (DMHCA).

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 completes the clinical mental health/substance abuse intake form. Youth needs are identified and referrals are completed as a part of the screening process. The program utilizes the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2). A review of the program's facility operating procedures (FOPs) determined the program has implemented a standardized admission/intake mental health and substance abuse screening process. The process includes a review of the commitment packet information, reports, records of the Department's Juvenile Justice Information System (JJIS) alerts, administration, and scoring of the MAYSI-2, staff training, and process for referral.

Five youth records were reviewed. The program reviewed the commitment packet information, reports, and JJIS alerts. Any existing mental health or substance abuse problems were documented for each of the five youth records. The MAYSI-2 was administered in the JJIS on the day of admission. As each youth's MAYSI-2 scoring had indicated a need for further assessments, the program completed a referral. None of the youth were in crisis during the screening process. An Assessment of Suicide Risk (ASR) was completed for each youth within twenty-four hours, as the MAYSI-2 category indicated a need for further assessment or other information obtained. The clinical mental health/substance abuse intake form was administered upon each of the five youth's admission in the program. All screenings were signed by the designated mental health clinician authority (DMHCA). None of the screenings determined an emergency. The staff documented a consultation with DMHCA for all five youth records.

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.	

Youth at the program who are identified by screenings in need of further evaluations must be referred for a comprehensive mental health evaluation and/or comprehensive substance abuse evaluation or updated evaluation.

The program's policy and five youth records were reviewed. Each of the youth were identified at screening as in need of further evaluation. Each of the youth had a new comprehensive evaluation completed within thirty calendar days of admission. Each of the comprehensive evaluations were reviewed by the designated mental health clinician authority (DMHCA). All evaluations had new information applicable to each youth, based upon current information provided by the youth, parent/guardian, and youth's records.

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.*	

Mental health and substance abuse treatment planning is required, as delineated in the program's policy. The policy focuses on providing mental health and/or substance abuse education interventions and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse. Treatment teams develop, review, and update treatment plans. The program is not contracted to provide substance abuse treatment; however, the program provides substance abuse education and holds a Chapter 397 license to address substance abuse treatment. The program provides Seeking Safety and Living in Balance to address substance abuse.

Five youth records were reviewed. Each youth was assigned to a treatment team upon arrival. The team was comprised of the youth, program administration, living unit representative, juvenile probation officer (JPO), and the parent/guardian. Each of the youth were determined in need of mental health treatment. Three of the five youth were determined in need of both mental health treatment and substance abuse education. Two youth did not require substance abuse education. Each youth record had documentation of each youth receiving individual and group therapy. Family counseling by the licensed mental health professional was completed when the parent/guardian was available.

The facility is licensed under Chapter 397. The license expires on March 23, 2021. Each non-licensed staff had documentation of being directly supervised by the designated mental health clinician authority (DMHCA). Each of the three youth who were determined to need both mental health treatment and substance abuse educational services were addressed appropriately in accordance with the youth's treatment plan. Each of the youth signed consent treatment forms. None of the youth required a court order for substance abuse evaluation and treatment. Each

youth had documentation of a properly executed Authority for Evaluation and Treatment (AET) form. All treatment notes were documented on the Counseling/Therapy Progress Notes, form MHSA 018.

Five staff were interviewed and each staff selected were direct care staff and reported they do not facilitate any mental health or substance abuse education groups. The DMHCA reported individual/group therapy is provided weekly or more, as needed.

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.*	

According to the program's policy, youth with mental disorders or substance abuse impairment must have an initial mental health/substance abuse treatment plan. The policy also addresses youth receiving a discharge mental health/substance abuse treatment plan, including recommendations.

Five youth mental health records were reviewed. An initial treatment plan was developed on the same day as the youth's admission for each of the youth reviewed. The reviewed youth individual treatment plan was developed within thirty days of the youth's admission. An initial treatment plan was developed on the Initial Mental Health/Substance Abuse Treatment Plan, form MHSA 015 for each of youth receiving a mental health/substance abuse education. Three of the five reviewed youth were applicable for both mental health treatment/substance abuse education. The remaining two youth were only applicable for mental health treatment. The program provides Seeking Safety, Aggressive Replacement Behavior (ART), and Living in Balance groups to address substances abuse. The Initial Mental Health Treatment plan was developed within seven days of the onset of treatment. Three of the five youth were prescribed psychotropic medication and the program also provided treatment within seven days of the Initial Psychiatric Diagnostic Interview. Individualized treatment plans were signed by the mental health clinical staff person and the appropriate treatment team members. Psychiatric services for three of the five youth including psychotropic medication and frequency of monitoring by psychiatrist was included in the initial treatment plan. Each youth had their individualized treatment plan completed on the Individualized Mental Health Treatment Plan, form MHSA 016. The plan reviews were completed on the Individualized Mental Health Treatment Plan Review, form MHSA 017.

Three closed youth records were reviewed in addition to five open youth records. Each of the three closed youth records received mental health/substance abuse education while in the program. Each of the three youth had a discharge plan documented on the Mental Health/Substance Abuse Treatment Discharge Plan, form MHSA 011. None of the youth were released on suicide risk during the scope of the review. The service needs of the youth were documented on the discharge plan. The mental health/substance abuse treatment discharge summary considered services such as therapy and substance abuse therapy. Documentation

included the summary being provided to the juvenile probation officer (JPO), parent/guardian, and the youth. Exit staffing date and the discharge plan date determined the plan was available for review. Exit staffing documented the discussion of the mental health treatment discharge summary with all appropriate parties prior to the youth's release date.

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 director and the designated mental health clinician authority (DMHCA) reported the program provides specialized Mental Health Overlay Services (MHOS) and Substance Abuse Education. The program's treatment services are provided in accordance with Florida Statutes, Administrative Rule, and the provider's contract. The program provides Seeking Safety, Aggressive Replacement Behavior (ART), and Living in Balance groups to address substance abuse.

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****	

Psychiatric services at the program are provided by a psychiatrist. The psychiatrist is a licensed physician under Chapter 458. Five youth records were reviewed. Three of the five youth entered the program on psychotropic medication. The remaining two youth were not prescribed psychotropic medication. The initial diagnostic interview was completed within fourteen days. The diagnostic interview contained all the elements specified in Rule 63N-1 for each applicable youth. A psychiatric evaluation was conducted within thirty days of intake and had documentation of monthly medication review. The psychiatrist had documentation of a brief representative in the treatment team on the psychiatric status for each of the three youth. None of the youth were prescribed a new medication, discontinued a medication, or had a significant change in any medication. Each youth had consent. The psychiatrist reported being on-site two days a month, every other Saturday as sign-in sheets validated this occurrence. A review of the provider's contract determined the program is in compliance.

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

The program has a written plan delineating the suicide prevention procedures. The plan included all the appropriate procedures. The program administrator reported mock drills are conducted monthly for all staff. The policy includes maintaining one-to-one supervision or constant supervision during suicide precautions. The procedures for the policy includes making a referral, communication with mental health staff, completing notifications to program, updating

and documenting the Department's Juvenile Justice Information System, provisions for immediate staff responses, and a mental health review process. The plan was reviewed on February 12, 2020 by the designated mental health clinician authority and the program director.

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.*	

Five youth records were viewed. Each of the five youth records reviewed were placed on suicide precautions. Precautionary observation (PO) was maintained for each youth until an Assessment of Suicide Risk (ASR) was completed. The ASR indicated PO could be discontinued. None of the youth warrant secure observation. The program does not utilize secure observation.

The program director developed policy and procedures for the program to address serious suicide attempts or serious self-inflicted injury to include a mortality review for a completed suicide. The review includes circumstances surrounding event, procedures, training, medical and mental health services, pleading factors, and recommendations.

Each ASR was documented in real time on the , Department's required form . A review of logbooks was conducted to determine beginning and ending times were documented. The ASR was reviewed within twenty hours by the designated mental health clinician authority (DMHCA) as the non-licensed staff completed the ASR. Youth were not lowered or discontinued until the non-licensed staff conferred with the DMHCA. The parent/guardians were notified in each case. The Department's Juvenile Justice Information System (JJIS) determined alerts were appropriately entered when applicable.

The program utilizes three non-licensed clinical staff. Each of the three non-licensed staff completed the required twenty hours of training and five supervised assessments under the direct supervision of DMHCA. Five staff reported notifying mental health if a youth expresses suicidal thoughts.

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.	

Five youth records were reviewed and each were placed on suicide precautions. In each case, the suicide precaution observation logs were completed. Logs were maintained in real time. Intervals of no more than thirty minutes were maintained and documented with the staff's signature who was completing the observation. The youth's behavior were documented and

logs were reviewed and signed daily by the mental health staff. Youth were not placed in a secure observation room as the program does not utilize secure observation rooms. Due to the COVID-19 pandemic, youth interviews were not conducted during this annual compliance review.

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.	

Seven in-service staff training records were reviewed. Each staff received the required six hours annual training on suicide prevention and implementation of suicide precautions. Training included mock suicide drills. Mock suicide drills were held no less than quarterly for each staff. Each staff participated in drills which documented the use of the suicide response kit, simulated contacting Emergency Medical Services (EMS), and simulating a “Code White.” A “Code White” is the term the program staff utilize to alert other staff of suicide attempts by youth at the program. Drills were conducted on February 1 and 11, 2020, December 9 and 31, 2019, June 6 and 23, 2019, and September 5 and 27, 2019.

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

The program has a written crisis intervention plan detailing the crisis intervention procedures which includes notification and alert system; means of referral including youth self-referral, communication, supervision, and documentation and review. The plan includes an Assessment of Suicide Risk (ASR) and Mental Status Examination (MSE). Mental health staff determines the danger of the youth to self and others based on these assessments. A clinical impression is conducted advising of supervision and treatment recommendations. Notifications are required by staff to inform the parent/guardian of the youth’s mental health status.

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's policy delineates a crisis assessment is to be conducted by the licensed mental health professional, the designated mental health clinician authority (DMHCA), or by each of the five non-licensed mental health clinical staff. The program has not had any crisis assessments since the last annual compliance review period. A review of the program's policy, crisis assessment tool, and staff training records determined the program is adequately prepared to conduct crisis assessments.

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's emergency care plan includes an immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Ch. 394 F.S. (Baker Act), transport for emergency substance abuse assessment and treatment under Ch. 397 F.S. (Marchman Act), documentation, training, and review.

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

The program did not utilize a Baker Act or Marchman Act procedure during this review period; however, this indicator rates as non-applicable.

Standard 4: Health Services

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

The program maintains a medical doctor who serves as the designated health authority (DHA). The DHA is a licensed physician with a clear and active licensed which expires on January 31, 2022. The DHA meets all requirements for independent and unsupervised practice in the state of Florida. The DHA specializes in Family Practice. The program does not have a Collaborative Practice Protocol in place, as they do not employ an advanced nurse practitioner or a physician assistant. The DHA has an agreement with a back-up physician if the DHA is unable to meet their obligations. The DHA is on-site for at least one day each week, for a period of two hours and is available twenty-four hours each day by telephone, if needed. The sign-in and sign-out logs for the previous six-months confirmed the DHA visits as required. The sign-in and sign-out logs confirmed the in and out times. However, on two occasions the doctor left the facility ten minutes early. According to the DHA interview, the DHA is on-site once a week to see youth, review policies, and meet with the nurse and staff. The DHA also reported being available by telephone to provide medical services to the youth seven day a week, twenty-four hours a day, 365 days a year.

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

The program utilizes facility operating procedures (FOPs) and treatment protocols for all health-related concerns. All FOPs contained the signatures of the registered nurse (RN), the designated health authority (DHA), and the program director. Documentation confirmed on February 7, 2020, the FOPs were reviewed and implemented. All treatment protocols contained the signatures of the DHA and the RN. Documentation confirmed medical staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures, which was provided by the RN. Documentation confirmed nursing staff completed the annual review of FOPs and signed the cover page.

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.	

A review of five youth individual healthcare records (IHCRs) confirmed each youth had a signed Authority for Evaluation and Treatment (AET). Two reviewed youth IHCRs were involved with the Department of Children and Families (DCF); however, only one youth parent/guardian parental rights were terminated after being admitted to the program. All AETs were received prior to the youth receiving medical treatment. Four AETs were stamped "copy", the remaining AET was the original. Copies of the parental notifications were maintained behind the AET in the youth's IHCR. According to the nursing staff interview, AET's are obtained from the Department's Juvenile Justice Information System website and placed in the youth IHCR. If a new AET is needed, the nurse works with the case manager to contact the youth's juvenile probation officer to obtain the AET.

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

A review of five youth individual healthcare records (IHCRs) found three were applicable for a parent/guardian notification. The three reviewed youth IHCRs indicated each youth was placed on medications not covered by the Authorization to Evaluation and Treatment (AET) form. Each instance documented telephone calls, or attempted telephone contacts, and verbal approvals were witnessed. In addition, the parental notifications were sent to the parent/guardian when applicable. In each of the three applicable IHCRs, the Clinical Psychotropic Progress Notes (CPPN) were required. Each IHCR documented consent on page three from the parent/guardian and was accompanied by a parental consent form. It is the program's practice of verifying each youth shot records prior to youth being admitted to the program. An evaluation of five youth IHCRs confirmed the program verified the vaccinations for each youth on the days of admission. During an interview with the nursing staff, notifications are required with any new medications, discontinued medications, change in the youth's status, emergencies with the youth, and off-site care for the youth except for the health department. All notifications were completed in written form, even if verbal contact was made. All notifications are documented in the medical record.

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.	

Five youth individual healthcare records (IHCRs) were reviewed for screenings upon admission for healthcare concerns. Each of the five reviewed IHCRs contained a completed facility entry physical health screening (FEPHS) form which was completed on the date of admission, by the registered nurse (RN). Each youth submitted to a pregnancy screening at the time of admission. One youth was applicable for a rescreening due to leaving the custody of the program staff. Upon the youth returning to the program, the RN completed a new FEPHS form.

One youth IHCR contained conflicting dates. The Department's Juvenile Justice Information System (JJIS) indicated the youth was admitted to the facility on October 28, 2019; however, documents completed at admission contained the date of October 16, 2019.

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 maintains a written policy and procedures which requires healthcare staff to provide orientation to each youth admitted to the program within twenty-four hours of admission. Five youth individual healthcare records (IHCRs) were reviewed for completion of orientation. In all five reviewed IHCRs, documentation revealed each youth participated in orientation to healthcare services. Youth orientation to healthcare services addressed all of the required topics including access to medical care, sick call, the right to refuse care, and what to do in the case of a sexual assault or attempted sexual assault, what constitutes and emergency, the role of healthcare staff at the program, and to notify staff immediately if they are having side effects from medications.

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 maintains a written policy and procedures which requires the designated health authority (DHA) to be notified immediately when a youth admitted requires emergency care or routine notification in accordance with Department's requirements. It is the program's practice to notify the DHA upon admission of each youth. Five youth individual healthcare records (IHCRs) were reviewed and each IHCR contained documentation the DHA was notified upon admission.

Three youth required DHA notification due to being identified as possessing a chronic condition. Each of the three IHCRs indicated the DHA was notified by fax upon the youths' admission to the program and each notification was documented in the youths' chronological progress notes. The chronic conditions logs were also updated as required and the program's notification of admission form.

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

The program maintains a written policy and procedures which requires healthcare staff to review and complete each youths' health related history. Five youth individual healthcare records (IHCRs) were reviewed. Each youth IHCR contained a completed Health-Related History (HRH) form, which was completed within seven days of admission to the program by the registered nurse. Documentation revealed the designated health authority (DHA) reviewed the HRH forms. Each HRH form was completed prior to completing the Comprehensive Physical Assessment (CPA). According to nursing staff interviews, if the HRH is completed prior to admission, it will be reviewed by the nurse with the youth upon intake.

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

The program maintains a written policy and procedures requiring all youth to receive a Comprehensive Physical Assessment (CPA). A review of five youth individual healthcare records (IHCRs) revealed a CPA was completed for each youth. In two youth IHCRs, medical staff reviewed the CPA within seven days of admission by a medical doctor. Three youth received a new CPA upon admission. All five CPAs documented the medical grade for each youth and were completed as required by Administrative Rule.

In the three IHCRs where a new CPA was completed upon admission, the youth voiced no concerns related to their private parts. Two of the three IHCRs contained a refusal form concerning the genital exam. The program was unable to produce the remaining youth refusal form. An evaluation of the Department's Problem List indicated it was updated for each youth, as required. The program maintains a written policy and procedures outlining all youth are required to be screened for tuberculosis (TB). A review of five youth IHCRs reflected each youth had a minimum of one verified tuberculosis skin test (TST) documented in each youth's IHCR. Each of the IHCRs documented Tier One TB screenings were completed upon admission or

prior to entering the program. An interview with the nurse revealed at the time of admission, the CPA is reviewed. If the youth is a med grade one and the CPA is within two years, a new CPA is needed. For any med grade two or higher, a CPA is due to be updated annually.

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

The program maintains a policy and procedures regarding the completion of sexually transmitted infection (STI)/human immunodeficiency virus (HIV) screenings. Five youth individual healthcare records (IHCRs) were reviewed, of which all five youth reported being sexually active. The program screened each youth for STIs and each youth submitted to a STI test on the day of admission.

Two youth IHCRs contained documentation of refusal of STI testing. The three applicable youth IHCRs, documented a consent for human immunodeficiency virus (HIV) testing along with pre-test and post-test counseling. The remaining applicable youth IHCR documented a consent for HIV testing; however, the youth has not submitted to the test due to the COVID-19 pandemic. According to the nurse, the two youth who consented to HIV testing, each received the test and the results were filed in a confidential manner. The results were in a sealed envelope marked “confidential” in the youth’s IHCR. Documentation indicated the programs utilizes the Madison County Health Department to provide testing and counseling service. Five youth were interviewed, four youth stated they can request a HIV test. The remaining youth stated they cannot request a 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.	

The program maintains a policy and procedures in place to conduct sick call for all youth in the program experiencing illness. The program utilizes a lock box to ensure youth do not have access to the completed sick call forms. All youth in the program can make sick call requests and have their complaints treated appropriately through the sick call process. Sick calls are conducted daily, as needed by a registered nurse. Medical staff reserve time seven days a week from 9:00 a.m. to 12:00 p.m. to address sick calls. When medical staff are not on-site, they are called and consulted to conduct sick calls. There were no youth complaints of any severe pain with which medical staff was unfamiliar with. None of the youth presented complaints three or more times within a two-week period. No sick call was observed during the annual compliance review.

Sick call request forms and narrative progress notes are conformed to the professional standard to include all elements of the subjective, objective, assessment, and plan (SOAP) format and documented treatment, education, and follow-up plans when appropriate. The program does not utilize restricted housing. The program maintains documentation of the sick calls log and all sick call request forms were stored in the youth IHCR.

A review of five IHCRs found four contained all the documentation required and the documentation matched the information on the Sick Call Log. In the remaining youth IHCR, one Sick Call Request Form and an entry from the Sick Call Log was missing. Five staff were interviewed concerning sick calls and all reported the nurses respond to sick calls. Five youth were interviewed and reported within one day of requesting a sick call, they are seen by the nurse.

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

The program maintains an established policy and procedures for the provision of episodic care, first aid, and emergency care. An evaluation of five youth individual healthcare records (IHCRs) revealed one youth was applicable for episodic care. The program was only able to provide one additional applicable youth IHCR for review. An evaluation of two applicable youth IHCRs found each contained appropriate documentation of the episodic care events. Each youth was evaluated and treated by medical staff. The program maintained an Episodic Care Log to document the provision of episodic care and first aid treatment. An evaluation of episodic care documentation found subjective, objective, assessment, and plan (SOAP) elements. An evaluation of the logs indicated episodic care was administered by the nursing staff. The program previous nursing staff also documented sick calls and first aid on the Episodic Care Log.

The program maintains a total of six first aid kits which three were inspected and contained all the approved content, as required and all contents were up-to-date. The program also has one automated external defibrillator (AED), which was tested and was functional during the annual compliance review. The pads expire on September 30, 2020 and the battery expires on July 31, 2021.

Documentation and interviews confirmed the nursing staff review inventory and restock all first aid kits weekly and documents the review on a log located on each first aid kit. An evaluation of the program medical drills confirmed the program conducts mock emergency medical drills monthly on each shift and sometimes conducting multiple drills a month. Five staff were interviewed and four reported they were able to call 9-1-1 if a youth has a medical emergency. The remaining staff reported if a nurse is not available, anyone can call. Five youth were interviewed and each reported they can see the doctor, if needed.

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

The program maintains a written policy and procedures to provide timely referrals and coordination of medical services for youth requiring off-site care. An evaluation of five youth individual health care records (IHCRs) revealed each was applicable for off-site care. The reviewed documents revealed the youth were transported off-site for issues ranging from human immunodeficiency virus (HIV) testing, dental work, and scoliosis. Documentation confirmed the designated health authority (DHA) was notified of the emergency event and each youth followed-up with the DHA. Each event was documented on the Episodic Care Log. The IHCRs contained a summary of Off-Site Care form and discharge instruction/treatment documents.

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

The program maintains a written policy and procedures for the delivery of treatment to youth identified as having a chronic medical condition. An evaluation of five youth individual healthcare records (IHCRs) found four youth were identified with a chronic medical condition at admission. The program identified youth chronic condition by utilizing the facility entry physical health screening (FEPHS) form. The remaining youth was identified with a chronic condition shortly after admission. The youth were classified according to their medical grade. The program maintained a chronic condition's roster to document the youth identified with chronic conditions and tracked the required treatment/evaluation. Periodic evaluations are documented in the youths' IHCR and treatment orders are written clearly for clinical staff. Documentation confirmed youth are evaluated prior to new medications being order or prescribed. There were no lapses in treatment and their Problem Lists were updated. An interview with the registered nurse confirmed, the program monitors youth with chronic conditions by utilizing a chronic health roster/log and track follow-up testing, referrals, and appointments in a medical tracking log.

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

The program maintains a written policy and procedures to ensure medication is received, stored, inventoried, and provided in a safe and effective manner. An evaluation of five youth individual healthcare records (IHCRs) found three youth were prescribed medication prior to their admission to the program. In each of the three IHCRs, the medication was verified and the youth was continued on medications. Verification of medication was documented in each youths' chronological progress notes and stored in the youths IHCR. The designated health authority (DHA) and when applicable the psychiatrist was contacted to obtain orders to resume the youth medication.

The program utilized the standard Department's Medication Administration Record (MAR) to document consumption and refusal of medications. The MAR documented all of the required information including medication start and stop dates, staff and youth initials of medication received. There were no lapses or errors in medication administration observed. The medical staff document weekly side effects monitoring on the MARs. The program maintains trained non-healthcare supervisor level staff to assist in the delivery of medications when licensed staff are not on-site. There were no refusals; however, the program's practice is to clearly document refusals on the MAR and Refusal Form, when applicable.

Five staff were interviewed and each reported medication is provided by the nursing staff. Four staff also reported trained/certified staff also provide medication. Five youth were interviewed and each stated they received medication from the nurse. One youth reported receiving medication from a supervisor.

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

The program maintains a written policy and procedures ensuring medical equipment classified as medications/sharps shall be secured and inventoried by using a routine perpetual inventory. An evaluation of the program's inventory was conducted, documentation revealed the program secured, locked, and inventoried all medications and medical equipment such as sharps by utilizing a routine perpetual inventory descending count as each sharp is utilized and disposed.

A review of the past six months of medications revealed all counts and inventories matched medications on-site. The number of pills, tablets, or dosages remaining after each administered dosage was documented on the youth's individualized controlled medication inventory record. According to the nurse, the program maintains an agreement with a consulting pharmacist to destroy expired/discontinued medication.

Prescribed and topical medications are stored in a locked medication cart which is stored in a locked closet. Controlled medication is stored within a locked box in the locked medical cart. Sharps, bulk, and over-the-counter (OTC) medication are stored separately in a locked cabinet within the medical clinic. Medication which require refrigeration are stored in a locked refrigerator which is situated in the medical clinic, which is inaccessible to youth.
A random inventory of three different sharps, three prescribed medications, and three (OTC) medications revealed each count was accurate and documented by nursing staff. There was documentation of shift-to-shift counts being conducted. A shift-to-shift inventory count of all medications and sharps were documented.

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 maintains a written policy requiring all staff and youth to receive education on infection control. An evaluation of the program's plan was conducted and confirmed the plan included the implemented infection control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases in accordance to Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines.

Youth receive infection control training upon admission and staff receive infection control training annually. The training includes prevention of bloodborne pathogens guidelines for hand-washing techniques, universal/precautions, and prevention/transmission of communicable diseases. According to the program director, the Exposure Control Plan is in all offices and the plan is reviewed annually or as needed.

Five reviewed youth individual healthcare records (IHCRs) confirmed each youth received infection control screening at admission. Infection control screening and training were completed by medical staff. The program utilizes the youth's facility entry physical health screening form, health-related history form, human immunodeficiency virus (HIV) risk assessment, sexually transmitted infections screening, and the comprehensive physical assessment to screen youth.

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

The program maintains a policy and procedures in place to provide in-depth health education and prenatal care for all pregnant youth. There is a nursing protocol and treatment plan in place for pregnant youth. Prenatal care begins immediately after a youth is determined to be pregnant. This care continues through discharge, transfer, and postpartum. There was one youth applicable for prenatal care since the last annual compliance review period. Documentation confirmed the youth was identified as being pregnant on the Facility Entry Physical Health Screening Form. The program immediately implemented all of the pregnancy procedures as required which included but not limited to, regular visits to a doctor, prenatal vitamins, and health education. The youth was placed on alert for diet and provided double portions of food to ensure the proper nutrition. The program does not have bunk beds. The youth were reviewed daily for danger signs during pregnancy and evaluated monthly by an obstetrician and the designated health authority (DHA) until the youth delivered the baby. The youth was discharged from the program upon delivery. The documentation in the IHCR of the applicable youth was consistent with these requirements through delivery. Documentation supported a licensed nurse provided in-service education annually to non-healthcare staff which includes monitoring and observation. The program also has access to the Partners for Health baby curriculum developed by Florida State University.

Standard 5: Safety and Security

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

The program has a policy and procedures for youth supervision. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, this indicator shall be reviewed at a later time. A follow-up visit was conducted on June 11, 2020 on-site at the program. The youth were observed in the class room and in the gymnasium. The program staff maintained the correct staff to youth ratio requirement in each setting of eight youth to one staff during awake hours. A staff who was supervising the youth was able to provide how many youth they were supervising, and were able to give the correct number without having to stop and count the youth. Five staff interviews revealed the procedures for when a count cannot be reconciled, all movement is stopped and a recount is conducted until all youth have been accounted for.

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

The program has a detailed written description of their behavior management system (BMS). The BMS was clearly written, posted, and in the youth handbook. A review of the BMS and contract found all appropriate parties were involved in the development, implementation, and on-going maintenance of the applicable BMS. A review of five youth case management records revealed the youth's orientation and/or handbook included a review of the program's BMS. The program's BMS has not changed since the last annual compliance review. A review of the program's BMS found it included all the required elements to include positive and negative consequences, opportunities for staff and youth to discuss impact of behavior on others and discussion of alternate behaviors. The program's BMS addressed a ration of four-to-one positive to negative consequences. The program director revealed rewards and consequences are monitored daily by shift supervisors and weekly by the dean of student services, student council and management review. Five interviewed youth revealed punishments included refocus which is a plan to correct behavior. All youth reported staff are consistent and will not give you what you do not deserve. Five youth reported they receive daily rewards from the daily rewards cabinet, participate in fun Friday's, and extra telephone calls. Five staff were interviewed and were able to explain the program's BMS. Five staff reported only privileges can be taken away from youth as consequences. A review of three pre-service and seven in-service staff training records revealed all received training on the BMS.

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.

A review of the program's policy and procedures found there is a protocol where staff are provided feedback regarding their implementation of the behavior management system (BMS). All staff at the program are responsible for the implementation of the program's BMS. The management team and corporate office are involved in the development, implementation, and on-going maintenance of the BMS. The program's BMS includes a process wherein staff explain to the youth the reason for any sanctions imposed prior to the end of the staff member's workday. The program does not use room restriction. A review of three pre-service and seven in-service staff training records revealed all received training in the program's BMS. The staff were trained in the jointly combined BMS plan to include use of BMS during school. An interview with the program director revealed the education staff was trained in the jointly combined BMS plan to include use of the BMS during school. The program director revealed implementation of the BMS is monitored to ensure it is administered fairly and consistently among all staff by performance evaluations and daily supervisor reviews. Staff interviews revealed youth are informed of the consequences verbally and youth are able to explain their behavior(s). Staff interviews revealed supervisors provide feedback to staff regarding the BMS during briefing before, after shift, and immediately when changes occur.

5.04 Ten-Minute Checks (Critical)	Satisfactory Compliance

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

The program has a total of twenty-two cameras which all are operational. The video recording is stored for up to thirty days. A desk audit observation was conducted due to the COVID-19 pandemic restrictions. The program provided a zip drive containing video footage of ten-minute checks being conducted. The program has two shifts and utilizes two sleeping quarters for youth. Direct care staff were observed conducting ten-minute checks in a manner to ensure the safety and security of each youth. The staff were observed utilizing a flashlight and pausing at each room occupied by a youth. Ten-minute checks were documented manually in real time. Four days were observed for both the first and second shifts of staff. Ten-minute check sheets were reviewed. The times documented on the check sheets matched the video. The room check sheets recorded when a youth was in the room, receiving counseling, in the bathroom, school, work, home visit, off-base, or completing detail. Staff printed and signed their name on the room sheets and documented checks in real time after completing a ten-minute check. Five staff were interviewed and two reported room checks are conducted every five minutes. One staff reported every ten-minutes and one reported every seven, eight, or nine minutes.

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.*	

A review of the program's policy and procedures concerning census, counts, and tracking revealed they are conducted as required. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, an observation of counts being conducted could not be observed during the week of the annual compliance review. A follow-up visit was conducted on June 11, 2020 on-site at the program of youth counts. A review of the logbook found the program is conducting counts at the beginning of each shift, after each outdoor activity, and during emergency situations. Five staff interviews revealed youth counts are conducted every moment, during shift change, and every thirty minutes. If there is a discrepancy, all movement is stopped and a recount is conducted. The supervisor ensures all youth are accounted for.

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 range of six months of log book entries were reviewed. Each logbook was bound with numbered pages. Each logbook entry was legible and included the date and time of the event, the names of staff and youth involved, a brief description of the event, the name and signature of the person making the entry, and the date and time of the entry. All entries were made in ink with no erasures or white-out areas. No logbook entries were obliterated or removed. Errors were struck through with a single line and initialed by the person correcting the error. Logbooks contained the required events and were maintained in chronological order. The logbooks, when applicable, contained internal incidents reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC).

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*	

A review of the program's written policy and procedures on key control was completed. The program's policy ensures the safety of staff, youth, and the public by implementing and maintaining a system of facility key control. Procedures delineate the process of key identification, recording of keys, key classification, inventory of keys, and lost, damage, or replaced keys. Observations were conducted by FaceTime due to the COVID-19 pandemic restrictions. Observations of the distribution and collection of keys conducted by master control determined compliance with the program's policy. An interview with five staff determined the process for restricting usage of keys such as medical, youth and staff records, personal property storage, evidence storage, and youth records is compliant with the program's policy. A review of the key inventory determined the key storage area was locked and inaccessible to youth, located in master control adjacent to human resources. Interviews with five staff determined they are knowledgeable of the program's policy and procedures for addressing missing or lost keys and the reporting and replacement of damaged keys. A random check of three staff for personal keys to include maintenance staff, office manager, and the program's facilitator determined compliance. Five staff were able to explain the program's key control process including how keys are assigned, the process for missing or lost keys, damaged keys, and restricted keys. All five interviewed staff reported their personal keys are placed in the designated key box. Staff keys are identified by numbers twelve, thirteen, and fourteen. Staff sign for their assigned keys. Keys are assigned at the beginning of the shift and returned at the end of the shift. If keys are missing, the facility is locked down, searches are conducted, the Department's Central Communications Center (CCC) is contacted, and an incident report is completed.

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 developed and implemented a system to prevent the introduction of contraband into the program. The program's policy ensures the safety of staff, youth, and visitors. The program procedures delineate what items are consider contraband and disposition of contraband. The list includes sharps, escape paraphernalia, tobacco, electronics, money, and keys. Youth are provided with this list of contraband and informed of the consequences. Staff maintains the safety and security of the program by performing searches when youth are brought into the program, searches of the facility, grounds, and incoming mail. The program din not have been any reports to the Department's Central Communications Center (CCC) concerning contraband with the scope of the annual compliance review period. The program director revealed room and building searches are conducted daily. If contraband or illegal contraband is discovered, it is placed in the chain of custody bags and law enforcement and the CCC are notified.

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 policy and procedures which address youth searches. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, this indicator shall be reviewed at a later time. A follow up on-site visit was conducted on June 11, 2020 to observe searches. Youth searches were observed and was conducted by a staff of the same gender. The youth searches were conducted according to the Protective Action Response (PAR) training manual. The youth was treated with dignity and respect to minimize the youth's stress and embarrassment. Five interviewed staff revealed youth searches are conducted after every activity to include before and after meals, and anytime youth are moved from one location in the program to another. Five interviewed youth revealed youth searches are conducted when returning from off campus, after outdoor activities, after visitation, after meals, and after work details.

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.	

A review of the invoices from the automotive shop confirmed each of the program's vehicle received an annual safety inspection and there were no deficiencies needing to be corrected. The program has a policy and procedures concerning youth searches. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, a transport or random checks of personal vehicles could not be observed during the week of the annual compliance review. A follow up visit will be conducted to observe at a later date. The program provided the review team with pictures to note each vehicle contained all of the required items for youth transports. A follow up on-site visit was conducted on June 11, 2020. Both vehicles were observed to be in good physical condition. Both vehicles received their annual inspections and regular scheduled maintenance, as required. All recommendations for maintenance and/or repairs were corrected by the certified auto mechanic during the inspection. Each vehicle has the appropriate number of seat belts, a seat belt cutter, a window punch, and a fire extinguisher. In addition, an approved first aid kit used for transport is maintained in the administrative office and the cell phone used for transport. It is the program's practice for each youth and each staff to wear seat belts during transportation. No youth can be attached to any part of the vehicle by any means other than the proper use of the seat belt. A transport was not observed during the annual compliance review. Upon inspection of the vehicles, passengers in the rear were able to open the door of the vehicle from the inside. However, the program has a wire screen over the door lock controls and black tape over the access points on the doors preventing the passengers in the rear of the van from opening the doors from the inside.

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.	

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, a transport or random checks of personal vehicles could not be observed during the week of the annual compliance review. A follow up visit will be conducted to observe at a later date. The program maintains a policy and procedures which establish the staff to youth ratio while on transport to ensure the safety and security of youth, staff, and the public. It is the program's policy to meet the minimum ratio of one staff for every five youth during transportation. According to the assistant program director, the program exceeds the minimum ratio by sending one additional staff on all transports; even if one youth is being transported, the program sends two staff. During the follow up visit, a random check of personal vehicles was conducted and all vehicles were locked when not in use except for two vehicles. The owners of the vehicles were notified and locked their vehicles. A transport was not observed. Five interviewed staff all revealed, staff are not allowed to use their personal vehicles to transport youth and staff are provided a cell phone for transporting youth.

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

The program has developed a policy and procedures outlining the audit/inspections for the program. A review of the program's policy and procedures revealed it meets all the requirements of F.A.C 63E-7.17(5). The recreational therapist and building manager are responsible for conducting the weekly security audits and safety inspections. A review of the weekly safety and security audits for the last six months revealed they were completed every seven days without any deficiencies. The program director revealed the process for identifying and tracking safety and security deficiencies is through daily inspections. The program director revealed all deficiencies are reviewed and corrected as soon as possible.

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's policy recognizes all program equipment and tools may be used as weapons or means of escape; therefore, inventory of tools must be maintained and kept secured. Procedures include an inventory list, tool inventory, tool identification, and missing or damage tools. Tools are maintained in a locked utility shed adjacent to the building and in the kitchen, such as knives and serving utensils. Observations were conducted by FaceTime due to the COVID-19 pandemic restrictions. The monitor, maintenance staff, and office manager participated in observations. Tools were marked and identified by tracing the tool on a shadow board. Tools could be easily identified by the outlining and identification made on the board. The program does not allow any youth to utilize any tools. The program provided daily and monthly tool inventory logs dating back to six months. Comparisons of the monthly inventory of tools and the daily inventory of tools with a high potential to be used as a weapon compared to the actual tools on the shadow board, determined there were no tools missing from the program nor any tools at the program not listed on the inventory. Five interviewed youth reported they do not handle tools. The maintenance staff also reported tools are restricted to the maintenance staff and the program facilitator.

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

The program has a written policy and procedures addressing youth tool handling and supervision. Youth do not handle tools at the program, as they are restricted. Staff interviews determined tools were not permitted to be utilized by the youth. All tools are stored in a locked room or secured in the kitchen when not in use. Five staff were able to identify the tools youth can use. Each staff reported mops and brooms. Five interviewed youth reported they only 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 policy and procedures for outside contractors were reviewed. A review of the sign-in sheets and/or instruction sheets for outside contractors was conducted. A review of project invoices submitted to the program by the vendors was conducted. The date the project was being worked on and/or completed matched the sign-in sheets of the outside repairmen or workers.

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

The program's policy and procedures revealed the program will conduct fire, safety, and evacuation drills in an effort to make sure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster. A review of the drills for the last twelve months found the program conducted as least one fire, safety, or evacuation drill monthly. The program has twelve fire extinguishers and provided documentation of each being inspected monthly. The program director revealed the program conducts drills monthly. Five youth interviews revealed they were instructed on what to do in case of a fire. Three of the interviewed youth stated fire drills are conducted once a month. One youth stated fire drills are conducted every two weeks. The remaining youth reported fire drills are conducted every week.

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

The program has a coordinated disaster plans and Continuity of Operations Plan (COOP). A review of the plan found it addresses alternative housing plans approved by the Department's regional director or designee. The program director revealed the COOP is located in the administrative assistance office, the program director's officer, medical, group living office, kitchen, recreation specialist's office, and the site compliance manager 's office. The plan is reviewed and updated annually. The plan was submitted to the Department for approval on March 30, 2020.

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

A review of the program's facility operating procedures on the storage and inventory of flammable, poisonous, and toxic items determined the program director maintains strict control of flammable, poisonous, and toxic items and materials and a complete inventory of all such items. Observations were conducted by FaceTime due to theCOVID-19 pandemic restrictions. Chemicals are maintained in a locked storage unit adjacent to the facility. All flammable, poisonous, and toxic material were stored securely. A review of the flammable, poisonous, and toxic items and materials inventory sent by e-mail determined each was accounted for. There were no items viewed which were not on the inventory Safety Data Sheet (SDS) list.

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.*	

A review of the program's facility operating procedures determines the program maintains strict control of flammable, poisonous, and toxic items and materials. Youth are not permitted to use, handle, or clean with dangerous or hazardous chemicals, or respond to chemical spills. Youth are not permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste. The program's prevention checklist determined maintenance schedules and repairs are conducted appropriately. Five youth were interviewed as to what chemicals, if any they have utilized in the program. Each youth reported they do not use any 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.	

A review of the program's procedures for disposal of flammable, poisonous and toxic items and materials determined it is accomplished within the parameters of state, local, and federal laws. An interview with the maintenance supervisor determined they are responsible for the safe and lawful disposal of these items. The program did not have to dispose of any chemical within the scope of the annual compliance review period. A review of the program's disposal log

determined there has not been a need for the disposal of any material during the annual compliance review period. Interviews with the program determined the Madison County Waste Management Center is identified for disposals.

5.21 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Non-Applicable
Programs choosing to participate in water-related activities shall develop and implement a water safety plan to ensure proper supervision and safety of the youth during water related activities. The plan shall also ensure staff are appropriately trained for each specific type of water activity. *Programs allowing youth to participate in water-related activities shall have a water safety plan addressing, at a minimum, safety issues, emergency procedures, and the rules to be followed during water-related activities, as follows:* • *Determination of the risk level for each participating youth, including whether or not the youth can swim, an assessment of swimming ability, and other factors to include age and maturity, special needs such as physical and mental health issues, and physical stature and conditioning;* • *Type of water, such as pool or open water;* • *Water conditions, such as clarity, turbulence, and bottom conditions;* • *Type of activity, such as swimming, boating, canoeing, rafting, snorkeling, scuba diving, and shoreline and offshore activities to include fishing from a bank or pier, fishing while wading, or picnicking close to a body of water.* • *Lifeguard-to-youth ratio and positioning of lifeguards;* • *Other staff supervision; and* • *Safety equipment needed for the activity, such as personal flotation devices when youth are in a boat, canoe, or raft, and availability of a lifeline during shoreline and offshore activities.* *Programs choosing to participate in water-related activities shall ensure staff are appropriately trained for each specific type of water activity.* *Programs choosing to participate in water-related activities shall assess each youth's aquatic ability prior to participation in water-related programming.*	

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

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

The program has a policy and procedures related to visitation, youth correspondence ,and the use of the telephone at the program. An interview with the program director revealed the program makes alternative visitation arrangements with parent/guardian. Youth visitation and telephone logs were reviewed to verify opportunities are made available to youth. Five youth interviews revealed they are given the opportunity to communicate with family members by mail, telephone, or at visitation. Visitation at the program is on Sunday's at 3:00 p.m. until 5:00 p.m. Family day is held every quarter.

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 does not utilize controlled observation; therefore, this indicator is rated 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 does not utilize controlled observation; therefore, this indicator is rated 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 does not utilize controlled observation; therefore, this indicator is rated non-applicable.

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

The program has a policy and procedures in place concerning safety planning for youth. A review of five youth records confirmed each youth had a safety plan. Each safety plan included warning signs, youth's baseline behaviors, crisis recognition, intervention strategies preferred by the youth, and debriefing preferences. Each of the safety plans were completed within fourteen days upon admission. Each of the plans were updated every thirty days or following any significant behavioral or mental health event identified by the youth's intervention and treatment team. Five youth interviews revealed each of the youth were involved in the development of their safety plan. Interviews with five staff revealed the safety plans were reviewed by the staff who have contact with the youth and were maintained in a location easily accessible to staff. Five staff interviews revealed safety plans are reviewed daily, monthly, when issues arise with the youth, during intake, debriefings, and formal treatment team meeting.