STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

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

Review Date(s): April 2-5, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Lea Herring, Office of Program Accountability, Lead Reviewer (Standard 1)
Warren Garrison, Office of Program Accountability, Regional Monitor (Standard 4)
Sarah Hollar, Programming & Technical Assistance, Technical Assistance Supervisor (SPEP and interviews)
Craig Swain, Office of Program Accountability, Regional Monitor (Standard 5)
Juan Youman, Office of Program Accountability, Regional Monitor (Standard 3)
Cynthia White, DJJ Probation, Circuit 8, Juvenile Probation Officer Supervisor (Standard 2)

Program Name: Joann Bridges Academy
Provider Name: Rite of Passage, Inc.
Location: Madison County / Circuit 3
Review Date(s): April 2-5, 2019

MQI Program Code: 1444
Contract Number: 10361
Number of Beds: 28
Lead Reviewer Code: 127

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- **2** # Case Managers
- **1** # Clinical Staff
- **1** # Food Service Personnel
- **1** # Healthcare Staff
- **1** # Maintenance Personnel
- **1** # Program Supervisors
- **5** # Staff
- **5** # Youth
- _____ # Other (listed by title): _____

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	* Initial Background Screening	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	* Provision of an Abuse-Free Environment	Satisfactory
1.04	* Management Response to Allegations	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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The 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 (ROP), through a contract with the Department. The program provides mental health overlay services (MHOS) to all youth in the program. In addition, the program fosters each youth by providing Dialectical Behavior Therapy (DBT), VOICES, and Aggressive Replacement Training (ART) as their delinquency intervention services. Additional treatment services provided include VOICES, Seeking Safety, Living in Balance, and Teen Relationships. Program administration and staffing is comprised of one program director, one administrative assistant, one compliance manager, one clinical director, one recreational therapist, four therapeutic managers, one transitional coordinator, two shift supervisors, sixteen full-time coach counselors (direct care staff), one part-time coach counselor, two registered nurses, and one building manager. Three coach counselor positions were vacant at the time of the annual compliance review. The provider, ROP provides the education services at the program. The layout of the program includes one large building housing the two female dorms, a large gym, cafeteria, and offices for administration.

Standard 1: Management Accountability

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

The program has a written policy and procedures requiring compliance with the Department's Background Screening Unit (BSU) requirements. Background screening is completed for all staff, contractors, volunteers, and interns prior to the date of hire or services being provided. There were eight staff applicable for an initial background screening during the annual compliance review period. A background screening was completed prior to the date of hire for seven of the eight staff records reviewed. One of the eight staff had a complete background screening completed one day after their date of hire. An interview with the program director (PD) revealed none of the staff had contact with the youth prior to receiving the background screening results. Seven of the eight staff records had a pre-employment assessment completed during the hiring process. One of the eight staff records were of the nurse and according to the PD, there is no specific assessment for the nurse's position. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed for both the Department and the school district-funded personnel and submitted to the BSU by the program on January 8, 2019, meeting the annual requirement. The program reported to have two volunteers at the program, but the PD reports they are at the program once a month less than ten hours a month.

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

The program has a written policy and procedures addressing five-year background rescreening/resubmission for all staff. According to the written policy and procedures, all staff receive a background rescreening every five years from the initial date of employment. There were no staff eligible for 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.

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

The program has a written policy and procedures for an abuse-free environment. The procedures specify if an abuse allegation is made or received by staff, it is to be immediately reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC). The written policy further states once an allegation is made or received, it is immediately reported to the shift supervisor, human resources department, and program director (PD). A written report is completed within one hour and the program director (PD) or designee immediately notifies local law enforcement and the local county social/human services office. A review of six months of the program's CCC reports included three instances of five staff accused of excessive use of force which were all unsubstantiated. A tour of the program revealed instructions for reporting suspected abuse, along with telephone numbers for the Florida Abuse Hotline and the CCC were posted throughout the facility. A review of five personnel records revealed staff adhered to a code of conduct as indicated by the staff's signature on the employee handbook. A review of staff interviews revealed each of the five staff stated the process for allowing a youth to call the Florida Abuse Hotline was to "immediately notify the shift supervisor and escort the youth to place the call." Staff interviews further revealed staff never observing a co-worker telling a youth they cannot call the Florida Abuse Hotline and never observing a co-worker use profanity when speaking to a youth. An interview with five youth revealed four of the five interviewed youth felt safe at the program. The one youth which responded they did not feel safe explained it was because the youth did not like some of the other youth and had to keep an eye out on the other youth. The youth further explained it was not due to the staff and did not want to call the Florida Abuse Hotline. All five youth reported never being stopped from calling or reporting abuse. Three youth stated staff are respectful. One youth stated no but was unable to explain and one youth reported half the time staff are respectful. Two youth reported never hearing a staff use profanity and three youth reported, occasionally. An interview with the PD revealed shift supervisors or administrative staff place all calls to the CCC and incident reporting procedures are followed, thereafter. The youth have access to the Florida Abuse Hotline and the shift supervisors will follow the incident reporting procedures following the abuse call.

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 facility administrator (FA) reported all staff receive training in appropriate behavior and the proper procedures to utilize when they have knowledge of abuse. According to the FA, staff are informed of their professional responsibility as mandatory reporters upon hire and youth are provided the telephone number to the Florida Abuse Hotline and the Department's Central Communications Center (CCC) during the intake process and the numbers are posted in each youth living area. The FA stated all reportable incidents are reported to the FA, assistant FA, or the supervisor within two hours of the incident and an internal investigation is initiated immediately. A review of internal investigation forms, incident report forms, and personnel action requests reflected management takes immediate action to address incidents of physical, psychological, and emotional abuse. An interview with the program director (PD) reported training is conducted with the youth and staff. Posting of the numbers are throughout the facility, all calls are logged into the CCC and the Florida Abuse Hotline call log. Reports are completed and turned into administration and filed. CCC/ Florida Abuse Hotline calls are discussed weekly in the management meetings and monthly in the staff meetings. An interview with the PD reported there were no disciplinary actions which resulted in allegations of abuse.

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

The program has a written policy and procedures for reporting incidents to the Department's Central Communications Center (CCC). The program reported a total of thirteen incidents to the CCC during the annual compliance review period. Each incident was reported to the CCC within two hours of the incident or within two hours of staff becoming aware of each incident. The program maintains a separate log to document when incidents are reported to the CCC. Incidents were also documented in the logbook. Upon review of internal incidents and grievances, it was determined there were no additional incidents which should have been reported to the CCC. An interview with the program director (PD) revealed the PD was familiar with the CCC reporting process.

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

The program has a policy and procedures in place regarding Protective Action Response (PAR). Five PAR reports were reviewed and each PAR report was completed by the end of the shift and reviewed by administration within twenty-four hours. Mechanical restraint was not used and no injuries occurred as a result of the PAR incident in any of the five reports reviewed. One

report had one staff listed on the PAR report but three staff provided statements. All five reports included post-PAR interviews and PAR medical reviews were completed as a precaution. Three of the five reports included a post-PAR interview sheet which documented the timeframe of the post-PAR interview within thirty minutes. The two remaining reports showed the post-PAR interview was completed by an administrator within thirty minutes but no timeframes were documented. An interview with the program director (PD) reported daily, weekly, and monthly monitoring is conducted on all PARs. JoAnn Bridges Academy has a PAR rate for the first quarter of .42, second quarter 0, and six-month rate of .23. The state rate for the first quarter was 1.55, second quarter 1.40, and six-month rate of 1.47.

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

Two training records for newly hired full-time staff were reviewed for pre-service training. The training records and documentation in the Department's Learning Managements System (SkillPro) confirmed each staff completed the required certifications prior to having contact with youth which included cardiopulmonary resuscitation (CPR), first aid, use of an automated external defibrillator (AED), and Protective Action Response (PAR). Documentation of orientation training for each staff included suicide prevention, child abuse reporting, emergency procedures, trauma informed care, the Prison Rape Elimination Act (PREA), ethics, and the contract required training. The pre-service training plan was submitted to the Department's Office of Staff Development and Training and was approved on January 31, 2019. All training was entered into SkillPro.

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

Five staff training records were reviewed for in-service training. The training records and documentation in the Department's Learning Management System (SkillPro) revealed the staff exceeded the required twenty-four hours of annual training for the 2018 calendar year. Each staff received an eight-hour Protective Action Response (PAR) update and maintained current certifications in cardiopulmonary resuscitation (CPR), first aid, and use of an automated external defibrillator (AED). Each staff received training on professionalism and ethics, trauma informed care, contract required training, and the Prison Rape Elimination Act (PREA). Each staff completed at least six hours of suicide prevention training. Training records for two supervisors documented each received at least eight hours of training in supervisory topics. The in-service training plan was submitted to the Department's Office of Staff Development and Training and was approved on January 31, 2019. All in-service training was entered into SkillPro.

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

The program has a written policy and procedures in place addressing the grievance process. The program's grievance process contains three phases such as informal, formal, and appeal. According to the program's procedures, during the informal phase staff must meet with the youth within twenty-four hours of the request being submitted. If the issue cannot be resolved during the informal phase, the youth may file a formal grievance. A response to the formal grievance must be completed within seventy-two hours of submission, excluding holidays and weekends. If the youth is unsatisfied with the response to the formal grievance, an appeal may be filed. The program director or designated administrator must provide a written response within seventy-two hours of receiving the appeal, excluding holidays and weekends. An interview with the program director revealed the grievance box is checked daily. Additionally, the program utilizes "Speak Out" forms. The program maintains copies of grievances for at least twelve months. A review of eight staff training records indicated the grievance process was completed. Five youth and five staff interviews revealed they could articulate the three phases of the grievance process. An interview with five youth reported they could ask for assistance in completing a grievance form.

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

Staff providing delinquency interventions had the requisite experience and training to provide the interventions. The interventions staff received training or certification on included Aggression Replacement Therapy (ART), Dialectic Behavior Therapy (DBT), Impact of Crime (IOC), VOICES, Seeking Safety, Living in Balance (LIB), and Teen Relationships. The program offers DBT, VOICES, and ART as their delinquency intervention services. VOICES and DBT are a promising practice with demonstrative effectiveness. ART and IOC are an evidenced-based practice. A review of five open youth records to include performance plans, revealed each youth is involved in a delinquency intervention. A review of sign-in sheets found each group was delivered as designed. The program's activity schedule consists of structured programming during at least sixty percent of the awake hours. An interview with program director confirmed the intervention services.

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

The program provides life and social skills groups which address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical

thinking. In addition, the program's policy revealed life skills classes include parenting/family skills, employment skills training, money management, health education, leisure activities, emotions management, and stress indicators. The daily activity schedule reflected life skills groups are conducted for one hour in the evenings each day. The logbooks and sign-in/attendance sheets reflected life skills groups are held in accordance with the activity schedule. Groups are facilitated by direct care staff. A review of seven staff training records reflected direct care staff are trained to deliver life skills curriculums. Five youth performance plans were reviewed and each reflected a goal related to life skills. Youth interviews revealed youth are receiving life skills training as outlined in the program's policy and activity schedule. An interview with the program director indicated life skills training is delivered daily for a minimum of one hour.

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 offers Impact of Crime (IOC) as their restorative justice groups for the youth. A review of seven staff training records revealed staff are trained to conduct restorative justice groups. The activity schedule includes daily groups which include restorative justice topics. Five reviewed youth records found youth participated in restorative justice groups. Youth have participated in community service projects which included serving meals at a church. An interview with the program director confirmed restorative justice awareness services.

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

The program designs its service and service delivery based on common characteristics of its primary population, to include age, gender, and special needs. The program addresses the needs of its female population through health and hygiene, physical environment, life skills training, and gender-specific recreation and leisure activities. The program utilizes the following practices such as safe space, time for conversations, opportunity to develop relationships, find a voice, body image, and women's health education. Programming includes Girls-Trauma Recovery & Empowerment (G-TREM), Seeking Safety, and VOICES. The program's activity schedule revealed these groups are taking place daily. According to an interview with the program director, the program addresses 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 policy and procedures for alerts. The program maintains a binder which contains an alert page for each youth. Logbooks documenting youth activity each day are also maintained for each unit (Diamonds and Pearls) and includes any alerts for each youth residing in the given dorm. Alerts for five youth were reviewed and the program alerts for all five youth were comparative to the alerts listed in the Department's Juvenile Justice Information System (JJIS). The program designated staff to enter alerts in the JJIS along with medical, mental health, and security staff responsible for entering alerts according to their category.

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

The program maintains three separate records for each youth which includes a case management, medical, and mental health record. All records were marked "confidential" and stored in file cabinets also marked "confidential." Medical records were maintained in the clinic and case management and treatment records were maintained in a separate office. The file tab for case management records included the required information such as the youth's name, date of birth, county of residence, committing offense, and a picture of the youth. The case management records were divided into the required sections (legal, demographic, correspondence, case management activities, and miscellaneous) with tabs within each section to separate specific forms.

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

The program's formal process to promote constructive input by youth is a student council. Meeting minutes for the student council were available for review as well as the schedule of meetings. Documentation revealed meetings were conducted weekly and youth were able to provide input on program activities. Interviews with five youth revealed the student council is utilized to provide input regarding events or anything occurring in the program. According to the program director, student council is used for youth input as are "Speak Out" forms.

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

The program has a community advisory board which schedules meetings quarterly. The community advisory board binder was available for review. The binder contained agendas, sign-in sheets, and minutes of the meetings for the past two years. The board consists of a pastor, local attorney, retired educator, school board member, former supervisor and current community mentor, and the director of the Refuge House; who is also a victim of domestic violence. One member has a child who was previously involved in the juvenile justice system. According the program director (PD), attempts were made to invite a member of the local law enforcement to join. Letters sent out to the prospective board members throughout the year were reviewed for verification. A telephone interview was conducted with a board member, who is a business owner and pastor. The board member reported being on the advisory board for eight to ten years and attends all meetings two to three times a year. Additionally, the PD stated the group makes suggestions on community projects and event, volunteers, facility improvements, and programming.

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 written policy and procedures in place for program planning and evaluation. Parent/guardian surveys are kept in the exit packets and reviewed by program administration when completed. Staff meetings are held monthly and management meetings are held weekly. Staff meeting minutes were available for review. Staff surveys revealed areas in which staff can improve and facility improvements were discussed. The surveys revealed staff felt staff meetings are an effective way in communicating this information. The program's practice to reduce staff turnover are to offer a competitive salary and benefits such as 401k, tuition assistance/reimbursement program, employee referral bonus program, affordable healthcare options, yearly bonus, and work schedules including consecutive days off. The program director provided Site Operations Summary (SOS) and Key Performance Indicator (KPI) reports which are shared with staff in an effort to communicate programming achievements and goals. Five staff were questioned if compliance reports were shared. Three of the five staff reported yes. Five staff were interviewed on how effective communication is at the program. One staff reported very good, three stated good, and one staff stated fair.

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

Five staff records were reviewed and a position description was present in each record. The position descriptions included standard work expectations and specific job duties, as related to the staff's position. The program's policy and procedures state performance evaluations will be completed after an employee completes their ninety-day probationary period and annually, thereafter. An interview with the program director stated performance evaluations were completed in accordance to policy. The evaluations address specific job responsibilities for each position. Interviews with five staff revealed they received performance evaluations. All five staff reported they receive annual evaluations.

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.	

A review of five youth case management records was completed. In four of the five records, the youth's parent/guardian were contacted via telephone within the required twenty-four hours upon each youth's arrival to the program. Five of the reviewed records contained a copy of letters which were sent to each youth's parent/guardian within forty-eight hours of the youth's admission to the program. Five of the reviewed records contained a copy of letters which were sent to each youth's committing court, assigned juvenile probation officer (JPO), and post residential services counselor, if applicable. A review of the five youth records reflected all letters were sent within the five-day timeframe requirement.

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.	

Upon a youth's arrival, the program provides an orientation to the youth which begins on the day of the youth's admission to the program. The program utilizes an orientation checklist which the youth and facility staff initial each component, sign, and date the checklist. The following services are discussed and/or provided to the youth during orientation the youth handbook, the daily schedule which is conspicuously posted to allow easy access and included in the youth handbook, expectations and responsibilities of the youth, availability of and access to medical and mental health services, information about the anticipated length of stay and expectations for release from the program, community access, grievance procedures, emergency procedures to include procedures for fire drills and building evacuation, physical design of the facility which are clearly posted in areas not accessible to the youth, information on contraband items and the possibility of prosecution which is also included in the youth handbook, performance planning, dress code and hygiene which is also included in the youth handbook, procedures on visitation, mail, use of the telephone, and access to the Florida Abuse Hotline or the Department's Central Communications Center (CCC) which is clearly posted. The youth's record and Electronic Commitment Packet (ECP) are reviewed prior to the youth arriving to the program. This information is used in assisting the program with an youth assignment to the living unit/room and the treatment team during the youth's orientation to the program. Five youth records were reviewed and reflected the youth received an orientation within twenty-four hours of being admitted to the program. Five youth were interviewed and all five youth indicated they received an orientation within twenty-four hours of being admitted to the program.

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

Eight youth case management records were reviewed and three were applicable to this indicator. During the youth's orientation, the youth signed a release of information forms. Two youth were eighteen years of age prior to their arrival to the program. Two youth records reflected the youth signed the release form at orientation. One youth record reflected the youth signed the release of information form at orientation and upon the youth's eighteenth birthday.

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

The program applies a multi-phase approach to analyzing, reviewing available information, and classifying or re-classifying youth based on the Florida Administrative Code. Prior to the youth's arrival to the program, the youth's history and Electronic Commitment Packet (ECP) is reviewed for safety and security risk factors and effective delivery of treatment of services. Upon the youth's arrival to the program, the youth is interviewed and the prior information is re-assessed during the orientation process. The Program Director was interviewed and indicated the program utilizes a form which includes but is not limited to physical characteristics, age, maturity level of the youth, identified special needs to include medical, mental health, development or intellectual and physical disabilities, history of violence, gang affiliation, criminal behavior, and sexual aggression including vulnerability to victimization, suspected risk factors of suicide, medical, escape, or security risk. Five youth case management records were reviewed and all records reflected the program utilizes a classification system. The classification system includes use of a classification form including the requirements in accordance with the Florida Administrative Code. Classification also includes assigned living unit, sleeping room, and youth group or staff advisor. Five youth records were reviewed and three records were not applicable to a re-assessment due to the youth not being in the program for more than sixty days. The remaining two records indicated the youth had not met the requirements for an increase in privileges or freedom of movement. During this review period, one youth did achieve an increase in privileges and the program provided the documentation to reflect the changes in the youth's privileges.

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

Seven youth case management records were reviewed and two were applicable. Both records reflected the local law enforcement, the program's educational provider, the youth's juvenile probation officer (JPO), and the post residential coordinator were notified. Both records reflected the notification of law enforcement in the youth's home county was not applicable due to the youth were identified as a gang member or having gang affiliation prior to their admittance into the program.

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

The program has a policy and procedures in place to address gathering of information on gangs. The policy states, all newly admitted youth will be screened to determine if the youth is a criminal street gang member or is affiliated with any criminal street gangs. Additionally, the intake staff will complete a gang questionnaire on each youth admitted to the program. The records reflected both youth participates in gang prevention and intervention strategies and their performance plans includes relevant goals and objectives. Both records reflected the youth participates in the gang court program at the facility.

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

A review of five youth case management records indicated five youth successfully completed a Residential Positive Achievement Change Tool (R-PACT) initial assessment within thirty days of admission. Two youth records were applicable for a re-assessment within ninety days. One of the two applicable records were completed within the ninety days for the R-PACT re-assessment. One record was one day late for completing the R-PACT re-assessment. All five R-PACT initial assessments and the two R-PACT re-assessments were documented and maintained in the Department's Juvenile Justice Information System (JJIS). A copy of the R-PACT initial assessment and R-PACT re-assessments were included in all five youth case management records.

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

A review of five youth case management records indicated all five youth had a Youth Needs Assessment Summary (YNAS) conducted within thirty days of admission. It was noted the program has a policy requiring the treatment team to complete a needs assessment within twenty-one calendar days of the youth's admission to the program. Each YNAS was documented and maintained in the Department's Juvenile Justice Information System (JJIS). A copy of the YNAS was included in all five youth case management records.

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

Five youth case management records were reviewed which indicated the intervention and treatment team including the youth, met and developed the performance plan based on the findings of the initial assessment of the youth within thirty days of the youth's admission to the program. In all five case records and for each goal, the performance plan specified target dates for completion, except for one target date expired for one goal. In all five case records and for each goal, the youth's responsibilities to accomplish the goal was specified. All five records indicated the performance plans addressed the youth's top three criminogenic risk factors. In all five case records and for each goal, the program's responsibility is to enable the youth to complete the goal which was not specified in four goals. The program amended the performance plan to include staff responsibilities in two of the four missed staff goals during the review period. One record was not applicable for the performance plan as the youth was not in the program for thirty days. Four records indicated within ten working days of completion of the performance plan, the program sent a transmittal letter and a copy of the plan to the committing court, the youth's juvenile probation officer (JPO), and the parent/guardian. None of the five records indicated involvement from the Department of Children and Families (DCF) caseworker or an Agency for Persons with Disability (APD) coordinator. Five youth were interviewed and all five youth indicated they participated in the development of their performance plan and goals. Four youth indicated they have a copy of their performance plan. One of the youth's performance plan was due during the annual compliance review. A copy of the completed performance plan which was pending, was provided to the reviewer and all the components and requirements were completed.

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.	

A review of five youth case management records indicated two of the records resulted in revisions to the youth's performance plan based on the R-PACT, new information, or the youth's progression towards completing goals. In addition, two plans were revised to facilitate transition activities during the last sixty days of the youth's stay. The Program Director was interviewed and indicated the program encourages parental involvement in the case management process via letters of invitation, phone calls, and video communication. In addition, the program has a policy and process to elicit parental participation in the development of the youth goals. The policy states "the performance contract goal proposal will be sent to the parent/guardian for signature along with a self-addressed stamped envelope within seven days of the youth's arrival." A review of the youth records reflected the form was completed and returned by the parent/guardian with input towards the youth's treatment needs.

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

The program has a policy and procedures in place regarding completion of performance summaries. A review of seven youth case management records found two were applicable for performance summaries.. Each of the initial ninety-day performance summaries were not completed within the ninety-day time frame. Of the two late summaries, one summary was fifteen days late and the second summary was four days late. During the review period, one youth was in the transition stage to exit the program and a second youth was beginning the transition stage to exit the program. A review of the performance summaries included the youth's status on each performance goal, the youth's overall treatment progress in relation to the youth's treatment plan, the youth's academic status and credits earned in the program, the youth's behavior, the youth's level of motivation/readiness to change, the youth's interaction with peers and staff, and the youth's significant positive and negative events. The justification for release or discharge was not clearly explained on one performance summary. All performance summaries were signed and dated by the treatment team leader, staff member preparing the summary, program director, and youth. Copies of the summaries were sent within ten working days to all required parties in each case. There were no youth records reviewed which required involvement from the Department of Children and Families (DCF) involvement. A signature sheet was sent to the parent/guardian in each case. No parent/guardian signature sheets were returned. Five youth were interviewed if they received a copy of their performance summary which was sent to the court. Two youth records from the interviews were applicable. One youth reported not receiving a copy of their performance summary. A review of the performance summaries from the applicable youth indicated both youth signed the performance summary and had the opportunity to include comments. Three records were applicable to

release. All three records indicated the original summary was sent with a Pre-Release Notification (PRN) and a signed copy was retained in the youth's case management record. All three records were sent at least forty-five days prior to the youth's planned release. The performance summary documented the justification was sent with the PRN or discharge summary. One justification was not clearly stated. Two of the PRNs was approved and one was pending approval by the committing judge. Copies of the approved PRNs were provided to the youth's parent/guardian. Documentation indicated the program provided the juvenile probation officer (JPO) with the performance plan, performance summary, psychological/psychiatric reports if applicable, and transition plan.

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

The program has a written policy and procedures in place regarding parent/guardian involvement in case management services. A review of five youth case management records indicated the program encouraged parent/guardian involvement during the assessment process, development of the performance plan, progress reviews, formal treatment teams, and transition plan, if applicable. Four of the five youth records documented parent/guardian notification within twenty-four hours of the youth's admission. An interview with the program director (PD) indicated the program completes letters inviting parents/guardians to participate in their child's treatment. The PD also stated telephone calls and video calls are made to parents/guardians to involve them in the youth's treatment. The program has a policy which states "the performance contract goal proposal will be sent to the parent/guardian for signature along with a self-addressed stamped envelope within seven-days of the youth's arrival." A review of the youth records reflected the form were completed and returned by the parent/guardian with input towards the youth's treatment needs. Five youth were interviewed and questioned if their parent/guardian were involved in the youth's case management. Four youth indicated yes. The youth reported their parent/guardian participates via telephone and personal visits. Another youth indicated staff listens to the parent/guardian concerns. Three youth records were reviewed for youth who were eighteen years of age. Two of the youth records indicated both youth were eighteen years of age at the time they were admitted to the program. During the orientation, both youth signed a waiver to release information. One record indicated the youth turned eighteen while in the program. A review of the record indicated the youth signed a release of information document during the orientation and at the time the youth turned eighteen.

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

The program has a written policy and procedures in place regarding the members of the treatment teams. A review of five youth case management records indicated all required program treatment team members participated in the formal treatment teams, which included representatives from program administration, treatment staff, direct care staff, education, and others responsible for providing or overseeing the provision of intervention and treatment services. The parent/guardian and the juvenile probation officer (JPO) were notified and invited to participate by mail, prior to the scheduled treatment team. There were no youth who required

involvement from the Agency for Persons Disability (APD) or Department of Children and Families (DCF).

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 in place regarding the incorporation of other plans into the performance plan. Five youth case management records were reviewed and three youth records were applicable to an academic plan and were incorporated into the performance plan. -Mental health, substance abuse treatment, and medical treatment was incorporated in the performance plans, if applicable and based on youth needs. There were no youth who required involvement from the Agency for Persons Disability (APD) or Department of Children and Families (DCF).

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

The program has a policy and procedures in place regarding formal treatment team meeting reviews. A review of five youth case management records indicated all youth had a formal treatment team meeting at least every thirty days. Documentation of formal performance reviews included the youth's name, date of review, meeting attendees, and comments from treatment team members. Three of the records did not document the required participants who did not attend the formal treatment team. All five youth records included a brief synopsis of the youth's progress in the program and any performance plan revisions. All five records indicated the treatment team reviewed the youth's progress on the performance plan goals, positive and negative behaviors, any behaviors which resulted in physical interventions, the youth were provided an opportunity to demonstrate skills acquired in the program, and any treatment progress. Five youth were interviewed if they were provided the opportunity during treatment team to demonstrate skills learned in the program. One youth stated they did not get the opportunity to demonstrate any skill learned. Another youth stated they did not have a formal treatment team meeting yet, and three youth stated they are provided the opportunity. Three records were applicable to a completion of a Residential Positive Achievement Test (R-PACT) re-assessment. Two of the three records indicated the R-PACT re-assessment results were discussed at the formal treatments reviews. It was indicated in all five youth records, the juvenile probation officer (JPO), the youth's parent/guardian, and any other pertinent parties were invited and encouraged to participate through advance notification. All pertinent parties were invited to provide input if participation in the treatment team meeting could not be arranged on all five cases. It was documented in all five youth records informal reviews are held one bi-weekly per

month and the youth are provided an opportunity to demonstrate skills acquired in the program. Four of the five youth records included documentation of a discussion of treatment progress and two records were applicable for an R-PACT re-assessment. One of the two records reflected the R-PACT re-assessment results were discussed at the informal treatment team review. The reviewer had the opportunity to observe a community re-entry team (CRT) meeting which was conducted via skype. All required staff were present to include education. All members were actively participating in the meeting and the youth was provided an opportunity to demonstrate the skills acquired in the program.

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

The program has career education programming based upon the age, assessed educational goals, and length of stay of youth to be served. The career education programming is Type 3. The program provides the opportunity for youth to learn culinary education, information technology (Microsoft Office), and medical skills (certified nursing assistant). A review of three youth case management records found each youth had a sample résumé and employment application, documentation of youth, parent/guardian, and juvenile probation officer (JPO) involvement. Two youth records had an appointment with Career Source. All youth had career courses and employability as a goal when released from the program. An interview with the lead teacher confirmed this practice. The career education course offerings are documented in the Skyward MIS system and are on file with the District School Board of Madison County.

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

The program has a school calendar which reflects the students participate in educational and career related programs for 240 days of instruction for students and ten days for teacher planning. The calendar reflects the 250 days of instruction are distributed over a twelve month period. A review of three closed youth case management records indicated the youth received credits for educational and training experience. Five youth were interviewed to ensure minimal interference of education instruction. Three of the five youth indicated there are a lot of interruptions during educational instruction. Some of the interruptions which were reported were the girls complain and whine, staff are playing around with other girls who don't have work, and girls talk back and forth and giggle sometimes.

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

The program has a policy and procedures in place regarding education transition. Three closed youth case management records were reviewed. Each youth had a transition plan based on their post release goals. The plans were developed in the beginning at admission. All three youth records indicated the education transition plan included key personnel to include but not limited to, the youth, parent/guardian, education representative, post release staff/re-entry personnel, school district personnel or guidance services program personnel, and registrar or

designee of the program's district. The education transition plan was developed with specific plans for continuation of education and/or employment. All three youth records indicated the education transition plan addressed at a minimum the services and interventions based on the student's assessed educational needs and post-release education plans, the recommended educational placement for post release which is based on individual needs and performance, and specific monitoring responsibilities by individuals who are responsible for the reintegration. All three records indicated the youth had employability as a transition goal. Two of the three records indicated the youth had a valid Florida identification card.

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.*	

Three youth case management records were reviewed for transition planning and conference. Documentation reflected each youth had a transition conference at least sixty days prior to the youth's projected release from the program. Each transition plan included appropriate goals and dates for the youth's release back into the community. All required participants including program staff, Department staff, and aftercare staff were invited to participate by telephone or in person. During the transition conference, participants were given the opportunity to review the transition activities on the youth's performance plan, revise the plan if necessary, identify additional transition activities if needed, and identify target completion dates. According to the transition coordinator, all parties received a copy of the transition plan. All three youth records indicated a community re-entry team (CRT) meeting was conducted prior to the youth's release. The youth and the case manager participated in the CRT. The reviewer had the opportunity to observe a CRT meeting which was conducted via skype. All required staff were present to include education. All members were actively participating in the meeting, and the youth was provided an opportunity to demonstrate the skills acquired in the program.

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 for an exit portfolio. Each of the records documented the youth was provided copies of all the required documents except for one youth who did not receive a copy of their state issued identification card. The program was able to provide documentation letters were sent to the youth's parent/guardian requesting assistance to gather the required information for the identification card. A review of three youth

records confirmed the program's practice to discuss exit portfolios with each youth at the youth's transition conference and exit conference. Further, the program provides the exit portfolio to the youth upon their release from the program.

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 in place regarding the exit conference. A review of three closed youth case management records found exit conferences were completed for each youth at least fourteen days prior to the youth's release. Documentation of the exit conferences included the date of the conference, signatures of participants, and any pending goals and final plans for transition activities. Each exit conference was attended either in person or via telephone by the youth, treatment team leader, education staff, parent/guardian, and other pertinent parties. The assigned juvenile probation officer (JPO) was in attendance by telephone for two of the three exit conferences. The remaining youth record indicated the assigned JPO was notified of the exit conference. A review of the Department's Juvenile Justice Information System (JJIS) found the date of admission and release dates matched for each youth.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor who serves as the designated mental health clinician authority (DMHCA). The DMHCA's license and position description were reviewed and found to be current as of the date of this review. The DMHCA's license expires on March 31, 2021. An interview with the DMHCA revealed the DHMCA is on-site forty hours per week, Monday through Friday and as needed on weekends to ensure the appropriate coordination and implementation of mental health and substance abuse services are taking place. The role of the DMHCA is to maintain a daily group schedule, monthly billing of services, report Standardized Program Evaluation Protocol (SPEP), oversee precautionary observation to include implementation and training of facility staff, review commitment packets of new admissions, create monthly reports per the Department, and work as a liaison between parent/guardian, juvenile probation officers (JPOs), and other outside agencies working with the youth. The DMHCA also supervisors two master's-level and one bachelor's-level therapeutic managers.

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

A review of the program's contract found staffing was in accordance with contract and Rule 63N-1, F.A.C. An interview with the designated mental health clinical authority (DMHCA) revealed the licensed clinical staff working under their supervision were performing services in which they are qualified to provide based on education, training, and experience. The program has one licensed mental health professional (LMHP). The license of the mental health professional was reviewed and found to be current. The LMHP license expires on March 31, 2021

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

The program has three non-licensed mental health and substance abuse therapists working at the program. The designated mental health clinical authority (DMHCA) assures the non-licensed clinical staff working under their supervision were performing services they are qualified to provide based on education, training, and experience. Two of the non-licensed clinical staff holds a master's-level degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field. The other non-licensed clinical staff holds a bachelor's-level degree from an accredited university or college and have fifty-two hours of pre-service training prior to working with youth. This staff member also has two years of clinical experience assessing, counseling, and treating youth with serious emotional disturbance or substance abuse problems. There was documentation of each non-licensed mental health and substance abuse clinical staff receiving at least one hour per week of on-site face-to-face direct supervision by the licensed clinical supervisor with the exception of the month of July. The program provided termination paperwork for the DMHCA. All three clinical staff missed two on-site face-to-face direct supervision by the licensed clinical supervisor. There was documentation confirming why the on-site face-to-face direct supervision were missed. There was documentation for one of the non-licensed mental health staff who conducted Assessments of Suicide Risk (ASR) receiving twenty hours of training and supervised experience in ASR. The training included administration of at a minimum, five assessments of ASR, or crisis assessments conducted on site in the physical presence of a licensed mental health professional. The training was documented on the Non-Licensed Mental Clinical Staff Person's Training in Assessment of Suicide Risk form (MHSA 002).

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.	

A review of five youth mental health records revealed each youth was screened using the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2). The MAYSI-2 was administered on the day of the youth's admission to the program in a confidential manner. The screenings were completed by a trained staff in the Department's Juvenile Justice Information System (JJIS). The program director (PD) developed written facility operation procedures (FOPs) for the implementation of a standardized admission/intake mental health and substance abuse process. The FOPs included all required elements. There was documentation of the staff conducting the screening reviewed each youth's commitment packet information, reports, and record for existing documentation of mental health or substance abuse problems. The PD revealed the program uses F.A.C 63N, the MAYSI-2, and suicide precautions to help with their screening process to identify youth at risk for mental health and substance abuse problems and suicide.

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

A review of the five youth mental health records found each of the youth were referred for a mental health and substance abuse assessment. Four of the five assessments were completed within thirty days of the youth's admission date. The other assessment was completed eleven days late. All were reviewed and signed by a licensed mental health clinical staff individual. Each of the assessments included the youth's identifying information, reason of evaluation, relevant background, behavioral observations, mental status examinations, and discussion of findings and recommendations. There was documentation of each youth giving consent for substance abuse services. The facility is licensed to conduct substance abuse treatment.

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.*	

A review of five youth mental health records found each youth was assigned to a multidisciplinary treatment team upon their admission to the program. The treatment team consists of the youth, the program's administration, the residential living unit, and other staff responsible for delinquency interventions and treatment services for the youth. A multidisciplinary treatment team meeting was not observed during the annual compliance review. A review of progress notes found each youth were receiving treatment services as indicated on the treatment plan. Each youth had a properly executed Authority to Evaluation and Treat (AET) and signed substance abuse consent and release forms. All therapeutic mangers provide substance abuse education and are qualified to provide substance abuse education. Mental health treatment notes were documented on the Department's Mental Health and Substance Abuse (MHSA) form 018. An interview with the program director revealed group therapy is limited to ten or fewer youth for mental health groups and fifteen or fewer for substance abuse treatment groups. Five staff were interviewed and each revealed they do not facilitate mental health or substance abuse groups.

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.*	

A review of five youth mental health records revealed each youth had an initial treatment plan developed. The treatment plan was on the Department's Mental Health and Substance Abuse (MHSA) form 015. Three of the plans were developed within seven days of the onset of treatment. One of the plans was developed two months late and the other plan was developed thirteen days late. The plans were signed by a mental health clinical staff and all treatment team members participated in the development of the plan. Each record also contained an individualized treatment plan developed for the youth within thirty days of the youth's admission or within thirty days of the initiation of treatment. The individualized treatment plans were signed by the mental health clinical staff completing the plan and all treatment team members who participated in the development of the plan. Each youth participates in individual, family, and group counseling. Three closed youth records were reviewed for discharge plans. Each youth had a discharge plan documented on the Department's Mental Health and Substance Abuse Treatment Discharge Summary form 011. There was documentation of each discharge plan being discussed with the youth, the parent/guardian (when available), and the juvenile probation officer (JPO) during the exit conference. A copy of the discharge plan was provided to the youth, the parent/guardian, and the juvenile probation officer (JPO).

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

The program provides specialized treatment services to youth. The program provides mental health overlay services and substance abuse education to youth. The program provides individual, group, and family therapy seven days a week. Therapeutic activities are provided by a mental health clinical staff daily. The program contracts a psychiatrist who is on site bi-weekly to provide psychiatric evaluations, medication management, and participates in treatment planning for youth receiving psychotropic medication. The program is licensed under Chapter 397, which allows them to provide substance abuse education. The program has arranged for a psychologist to provide services, as needed. Each counselor has an average of nine to ten youth on their caseload.

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.	

Psychiatric services are provided by a psychiatrist licensed under Chapter 485 or 459. The license of the psychiatrist was reviewed during the review and found to be clear and active with an expiration date of January 31, 2020. Five youth mental health records were reviewed and three were applicable for this indicator. Each of the youth records contained an initial diagnostic psychiatric interview. The initial diagnostic psychiatric interview was documented on a form developed by the program and was clearly identified as an initial diagnostic psychiatric interview. The form included all of the required information. Each of the three youth were receiving psychotropic medication. There was documentation of each youth being seen for medication review by the psychiatrist, at a minimum every thirty days. An interview with the program director revealed the psychiatrist was on site bi-weekly and available to evaluate and monitor youth, as needed. The psychiatrist is also available for emergency consultation twenty-four hours a day, seven days a week. The program does not have standing orders or emergency treatment orders for psychotropic medications.

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 detailing suicide prevention procedures. The plan includes the identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, review process. The plan was reviewed on March 11, 2019. The program director revealed the program conducts mock drills monthly and quarterly to include medical suicide, disaster, and fire drills.

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.*	

A review of five youth mental health records were reviewed and two were applicable for this indicator. An additional youth record was reviewed. One of the youth was determined to be at risk during the admission screening. The other two youth were determined to be at risk by staff observation. Each of the youth were placed on precautionary observation and the Assessment

of Suicide Risk (ASR) was completed on the required Department's Mental Health and Substance Abuse (MHSA) form 004. There was documentation of all three non-licensed clinical staff completed twenty hours of the required training by a licensed professional, including five co-assessments. The suicide precaution observation logs were completed for each of the youth. A follow-up ASR was completed before each youth was removed from precautionary observation. There was documentation on the ASR of a conference being held by the program director and the licensed mental health professional (LMHP) to reduce the level of supervision. Two youth were stepped down to close supervision and one youth was stepped down to standard supervision. A review of five staff interviews revealed staff notify the designated mental health clinician authority (DMHCA), medical, the supervisor and the program director, search the youth room, place the youth on constant sight and sound, and document supervision. Both youth placed on close supervision were maintained until it was determined no longer necessary by the DMHCA or the LMHP. The program does not use secure observation. The program has a total of seven suicide response kits. The suicide prevention plan documented a review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention and a mortality review for a completed suicide established by the program director. The multidisciplinary review includes circumstances surrounding event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, recommendations, if any for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

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

The suicide precaution observation logs for the three youth were reviewed on precautionary observation. The suicide precaution observation logs were maintained for the duration the youth were on suicide precautions. There were no warning signs requiring to be noted on the logs. Each of the precautionary observation logs were reviewed and signed by the shift supervisor and mental health clinical staff. Each log documented safe housing requirements. The two youth placed on precautionary observation were interviewed and revealed staff were watching them at all times. One youth revealed staff was with the youth while using the restroom, the door remained open but staff was not watching the youth use the restroom.

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.	

A review of seven staff training records were conducted. Each staff had the required six hours of suicide prevention training to include two hours of SkillPro and four hours of webinar or instructor led. Each of the staff were involved in monthly mock suicide drills on each shift. The mock suicide drills included all the required actions to be taken by staff. There was documentation of staff members who were not present during the mock drills having the opportunity to review the drill scenario and procedures in an effort to understand the process and receive the necessary training during monthly staff meetings.

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. The plan included the notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and a review.

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

The program has a policy and procedures in place for crisis assessments. Five youth mental health records were reviewed and one youth received a crisis assessment. Two additional youth records were reviewed. Each crisis assessment was conducted on the day the youth was determined to be in crisis. Each of the crisis assessment included all of the required information. Once the crisis assessments were completed the program director and the designated mental health clinician authority (DMHCA) were notified of the findings and special instructions. A mental health alert was entered for the youth in the Department's Juvenile Justice Information System (JJIS). All three crisis assessments were completed by a licensed mental health professional (LMHP) or a non-licensed mental health professional under the supervision of a LMHP. The crisis assessments completed by a non-licensed mental health staff were reviewed by a licensed mental health staff within twenty-four hours of the referral. A mental health clinical staff continued to follow up with the youth in accordance with the follow-up plan on the crisis assessment until a mental status examination was conducted by a mental health clinical staff and determined the youth's crisis has been resolved.

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

The program has an emergency mental health and substance abuse service plan. The plan includes 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 FS (Baker Act), transport for emergency substance abuse assessment and treatment under Ch. 397 (Marchman Act), documentation, training, and review.

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

The program had one youth who received a Baker or Marchman Act during the last annual compliance review. An Assessment of Suicide Risk was completed by a licensed mental health professional. The youth was determined to be in need of emergency care through staff observation. The youth was placed on one to one supervision and transported to the facility by program staff. Upon return to the program the youth was placed on constant supervision and a mental health referral was completed indicating a mental status examination needed to be conducted.

Standard 4: Health Services

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

The program has a contract with a licensed physician. The licensed is unrestricted and meets all the required independent and unsupervised practices in Florida. According to the Department of Health, the physician has a specialty certification with the American Board of Family Medicine. The program does not utilize an advanced registered nurse practitioner (ARNP). The physician is the designated health authority (DHA). Documentation includes the DHA communicates with staff regarding youth medical needs as the program maintains a list of youth and their medical needs. The contract requires the physician to be licensed per Chapter 458 as the physician is licensed in the practice of medicine. Sign-in sheets validated the DHA is on site weekly, every Tuesday. An interview with the DHA verified the role of the DHA. The DHA coordinates and implements all the health services provided to the youth at the program. The DHA visits with each youth needing services, each Tuesday.

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

The designated health authority (DHA) and the registered nurse (RN) signatures were located on the facility's operating procedures (FOPs) cover page to include the effective and revision date. The same practice was verified on other protocols and procedures. A review of all orientation documentations revealed a RN was hired. The RN received a comprehensive clinical orientation on December 20, 2018, as the RN was a newly employed healthcare personnel. The review and development of the FOPs related to psychiatric services and psychotropic medication management were signed by the psychiatrist. All treatment protocols and standing procedures were written and authorized by the DHA. The review and development of the FOPs related to psychiatric services was performed by the licensed mental health clinician (LMHC). The policies, procedures, and treatment protocols outlined the program's healthcare services. The health related polices, protocols, and procedures all delineates the program's healthcare services as the program has a comprehensive healthcare system providing services including two RNs, a physician, a psychiatrist, an optometrist, and utilizing the Women's Pregnancy Center and the Madison County Start Program.

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

Five youth healthcare records were reviewed and each youth had a copy of the Authority for Evaluation and Treatment (AET) filed in each of the youth's Individual HealthCare Record (IHCR) with the program stamping the word "copy" on each AET. Each AET was signed by the parent/guardian and witnessed by a Department representative. Each AET was valid. No parent refused to sign the AET.

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

A review of the programs facility's operating procedures (FOPs) policy states the parent/guardian are notified of significant changes in the youth's condition and/or when new medications are prescribed. Procedures allow for parental notification to be documented on the Parental Notification of Health-Related Care: Medication Management form 021. For medication treatment and medication changes, procedures allow for a written notification form with sufficient information about the medication to be mailed to the parent/guardian within three calendar days of the telephone call. Five youth individual healthcare records were reviewed and four youth had a documentation of changes in the youth's health status. One youth did not have any changes. The Parental Notification of Health-Related Care form 020 was utilized for each of the four youth's health status. Three of the five youth had significant changes in their medication, such as discontinuation of medication or medication for a chronic illness. Each of the three youth records had documentation the program utilizes form 021. None of the youth required vaccinations/immunizations orders. Off-site emergency care and medical treatment was required for one of the selected youth and parental notification was sent.. Two of the five youth required new medication. The progress notes documented the program notified the parent. All verbal notifications were followed up with a written parental notification. None of the parental notification was returned with a signature from the parent/guardian regardless of the attempts made by the program.

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

Five youth individual healthcare records were reviewed and four youth were receiving medication. Two were prescribed psychotropic medication. Page three of the Clinical Psychotropic Progress Note (CPPN) and explanatory information of psychotropic medication was mailed to the parent/guardian for each of the two youth. Progress notes confirmed the parent/guardian verbal consent was obtained for each of the two youth. The program maintains a log documenting when page three of the CPPN was mailed utilizing certified mailing options. However, as the program director and the RN reported, the parent/guardian rarely signs and returns page three of the CPPN to the program.

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

Five youth individual healthcare records were reviewed and each record was complete with the youth's history of immunizations received prior to the Department. None of the parents claimed exemption. Nursing staff reported the juvenile probation officers (JPO) utilizes the Department's Juvenile Justice Information System (JJIS) to upload the youth's immunization records. The information is transmitted via JJIS.

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

The Faciliatory Entry Physical Health Screening (FEPHS) was utilized for each of the five youth individual healthcare records reviewed. Each screening displayed the signature of the registered nurse (RN), as the RN completed the screening. Five staff reported they are notified of medical alerts by utilizing the alert book, logbooks, and shift debriefings.

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

The program utilizes an internal medical alert sheet capturing each youth's medical grades. Five youth individual healthcare records were reviewed and three had a medical grade of three to five. Each were captured on the program's alert system and the registered nurse (RN) verified all alerts and signed the log daily.

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

According to the policy, youth at the program received a health education orientation. Procedurally, the program provides health education as a part of the screening process. Five youth individual healthcare records (IHCRs) were reviewed. Each IHCR contained documentation the youth received an orientation. The program's orientation process included all appropriate topics. A review of the healthcare contacts ensured contacts were accurate.

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

Five youth individual healthcare records were reviewed and four youth had a chronic medical condition which did not require emergency care. The youth were referred to the designated health authority (DHA) who is also the physician. None of the youth required emergency care following their admission to the program. The medical protocols documented a list of all medical emergency conditions requiring notification to the DHA.

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

Five youth individual healthcare records were reviewed and one youth had a change in physical custody. A new Facility Entry Physical Health Screening (FEPHS) was completed by the registered nurse (RN) upon the youth's return to the program.

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

Five youth individual healthcare records were reviewed and each youth had a Health- Related History (HRH) conducted within seven days of the youth's admission. The designated health authority (DHA)reviewed the HRH. A new HRH was completed for each youth. A review of the signature revealed the HRH was completed upon the youth's arrival to the program.

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

Five youth individual healthcare records were reviewed and each youth had documentation a current Comprehensive Physical Assessment (CPA) was completed within seven calendar days from the youth's admission. The CPA was completed by the DHA. The medical grade was documented and all fields were completed on each CPA The DHA completed the examination. The facility operating procedures (FOPs) did not address when any part of the exam is not conducted and/or refused by the youth. However, the program's written protocol is to document all youth refusals. The Department's problem list was updated, as required.

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

Five youth individual healthcare records were reviewed and each youth were offered a gynecological exam, including a urine screening pregnancy exam at the time of their admission to the program. Two youth refused the screening upon their admission. The program completed the screening for each of the youth excluding the two refusals.

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

Five youth individual healthcare records (IHCRs) were reviewed. There was a verified tuberculin skin test (TST) in each IHCR. Tier I Tuberculous (TB) screening was completed within seventy-two hours of the youth's admission to the program. None of the youth had symptoms suggestive of active TB. A review of the Facility Entry Physical Health Screening (FEPHS) form and the Comprehensive Physical Assessment (CPA) indicated both4 had documentation of the completed TST results.

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

Five youth individual healthcare records were reviewed and each youth required a sexually transmitted infection (STI) screening. One youth refused the STI screening. One youth results

was still pending after taking the test a day before the annual compliance review. The remaining three youth test results were noted on the Infectious and Communicable Disease (ICD) form and located on each youth's IHCR. A rescreening was not required for any of the youth. A review of the health-related history (HRH) and the STI forms had documentation of the screenings. All the results were filed in the lab section of each youth's IHCR.

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

Five youth individual healthcare records were reviewed. The program utilizes the Madison Health Department to conduct the testing. According to progress notes, three youth HIV results were filed in a confidential manner consistent with FS 381.004. Two youth HIV results were pending. Documentation of pre-test and post-test counseling was located on the individual Health Education Record (HER) and the progress notes. The results were released to the program following the Health Department receiving a signed consent and release form stating the program nursing staff can obtain the information. The results were not released to any other party. The HIV results were not included on the program's internal alert system. Each of the results were disclosed in accordance with Chapter 381 F.S. Five youth were interviewed and each indicated they can request a HIV test.

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

The program conducts sick calls every day at 9:00 am. The program has two licensed nurses to ensure sick calls are conduct by only licensed staff. The sick call request box is secured by a lock and located in each of the dormitories. Five youth individual healthcare records (IHCRs) were reviewed. Four youth completed a sick call request and none of the youth complained of severe pain for three or more times within a two-week period.

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

Five youth individual healthcare records (IHCRs) were reviewed and three youth progress notes documented a sick call. Two youth did not request a sick call. The documentation was in accordance with the Florida Administrative Rule. The completed sick call request forms was placed in a secured lock box in each of the youth's dormitory hallways. The program has two licensed nurses to ensure sick calls are conduct by only licensed staff. A review of the sick call request log documented each of the four youth requests. A sick call was observed, the youth provided verbal consent there were no other youth present and the youth was examined by the registered nurse (RN).

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

The program contract states they do not use restricted housing; therefore, this indicator rates as "non-applicable."

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

The program provides basic first aid procedures and interventions. According the facility operating procedures (FOPs), the program provides twenty-four hours per day emergency medical and dental care. The program has a total of four first aid kits. The program has two dormitories and a first aid kit is located on the wall in each dorm. The program utilizes two vehicles to transport youth and when not in use, the program stores the first aid kits in the room utilized for medication storage. A review of the first aid kits revealed each kit was monitored weekly by the registered nurses (RNs) and replenished, as needed. A review of the progress notes and the non-healthcare staff forms revealed three youth required on/off-site episodic/first aid care. The non-healthcare staff episodic documentation included all the required elements. The documentation included problem-oriented and plan elements. The program utilizes an on-site episodic care log. The logs captured each of the three youth episodic care.

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

The program reported drills are documented in the drill logbook. The drill logbook records all medical and mental health drills. Drills are conducted twice a month for each shift and documentations recorded the scenarios of staff using cardiopulmonary resuscitation (CPR) or first aid. A review of seven staff training records were reviewed and each staff received training in first aid, basic CPR, and the use of the epinephrine auto injector. The program utilizes an automated external defibrillator (AED) which is placed in the room utilized for medication storage. The registered nurse (RN) completed a test of the AED and provided dates the last time the batteries and pads were replaced. The batteries expire on July 31, 2021 and the pads expire on September 30, 2020. The AED is checked daily as it was documented for the past six months. The two RNs also maintains a current certification in first aid, CPR and epinephrine auto injector. A list of emergency telephone and mobile numbers, including the poison information center was in administration. There were no youth requiring the use of an epinephrine auto injector. Five staff interviews confirmed they are permitted to call 9-1-1 when a youth is identified with a medical emergency.

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

Five youth individual healthcare records (IHCRs) were reviewed which included three youth requiring off-site medical or emergency care. The designated health authority (DHA) signed each of the off-site care findings and parental notification was completed. Each of the youth received follow-up care and were tracked on the episodic care log.

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

Five youth individual healthcare records (IHCRs) were reviewed. A review of the Facility Physical Entry Physical Health Screening (FEPHS) form and chronic conditions roster indicated three youth required periodic evaluations. All periodic evaluations were conducted no less than every three months as indicated on the progress notes and the youth's FEPHS form. The program director's interview revealed the program has weekly meetings designed for healthcare staff to review medical issues pertaining to the youth at the program. The two registered nurses (RN) and the designated health authority (DHA) both reported periodic evaluations are conducted no less than every three months.

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

Five youth individual healthcare records (IHCRs) were reviewed and three youth entered the program on medication. Each of the three youth's medication regimen was verified upon admission as indicated on the chronological progress notes in the IHCR. A registered nurse (RN) was on duty when the three youth were admitted. According to the program's facility operating procedures (FOPs), the designated health authority (DHA) designates and trained non-health-care staff to verify the medication and assist youth with self-administration. The progress notes indicated the DHA and the parent/guardian where notified for each of the three youth.

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

Five youth individual healthcare records (IHCRs) were reviewed and three youth required medication management. Of the remaining two youth, one refused their medication and the other youth did not require medication. All medications were current, had a valid order, and were given pursuant of the current prescription. There were no lapses in dosage. The designated health authority (DHA) placed an order for each youth's medication on the Practitioner Order Form. The progress notes indicated each of the three youth's current medications, discontinued medication, or new medication.

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

Five youth individual healthcare records (IHCRs) were reviewed. All medications are stored in a separate and secure areas inaccessible to youth. All non-controlled, prescribed, and over-the-counter (OTC) medications were stored in a separate, secure locked area inaccessible to youth.

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

Five youth individual healthcare records (IHCRs) were reviewed and three youth required medication management. All medications and sharps were inventoried as per Department requirements by the nurse. Observations included three sharps. Each sharp was secured and inventoried by using a routine perpetual inventory descending count as each sharp is utilized. The count matched the ending inventory number. The stocked supply was securely stored. A month of perpetual daily running inventory of medication was reviewed. The utilization for all prescription and over-the-counter (OTC) medications were maintained on the perpetual daily inventory. A weekly inventory counts for all opened OTC medications was observed.

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

Five youth individual healthcare records (IHCRs) were reviewed and three youth required medication management. Each of the three youth's medication was inventoried, stored, and documented per the Board of Pharmacy and Department requirements. The program utilizes a locked room in the gymnasium to maintain all medication. The medication storage area and the medication cart are secured with a double-lock system, to include the narcotics being secured in the medication cart with another lock. A shift-to-shift inventory count of each narcotic was conducted for the past six months and documented on each of the three youth's individualized Controlled Medication Inventory Record. The program's facility operating procedures (FOPs) delineates the program's shift-to-shift procedure as the program completes a medication inventory each shift. The number of pills, tablets, and dosages remaining were documented on the youth's individualized Controlled Medication Inventory Record.

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

Five youth individual healthcare records (IHCRs) were reviewed and three youth required medication management as indicated on the Facility Physical Entry Physical Health Screening (FEPHS) form. The program utilized the standard Department's Medication Administration Record (MAR) for each of the three youth. The MAR contained all the required elements. The initial MAR matched the medication list. The MAR clearly indicated the three youth orders start

and stop dates. Staff initialed each medication when administered. There were no lapses in medication.

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

An observation of medication administration was reviewed. The working space was clean and organized as the program utilizes the medication cart and an area designated in the gymnasium to administer medication. The nurse had control of the medication containers and cart. The youth did not have any contact with other medication(s) or the medication cart. The nurse verified the Five Rights of Medication Administration, the correct Medication Administration Records (MAR), and documented any relevant side effects on the MAR. Five youth reported the nurse and the doctors administers medication. The program had one pregnant youth but parenteral medication was not administered by the program. The program utilizes the Women's Pregnancy Center for parenteral medication. One youth refused their medication which was clearly documented on the MAR.

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

Trained non-healthcare staff assist youth with self-administration of medications, when the non-licensed nurse is not on site. A review of three staff training records verified staff were trained to assist with the self-administration of medications. The facility operating procedures (FOPs) delineates a structured process for youth to approach the non-healthcare staff person individually. Five youth were interviewed and each reported staff, the doctor, and the nurse administers medication.

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

Five youth individual healthcare records (IHCRs) were reviewed and three youth required medication management as indicated on the Facility Physical Entry Physical Health Screening (FEPHS) form. Progress notes indicated each of the three youth were currently prescribed psychotropic medications upon their admission to the program. The designated health authority (DHA) was notified in each case. The medication was continued to be administered following the initial diagnostic psychiatric interview of the youth within fourteen days. Each of the three youth received medication monitoring by the psychiatrist. There were no emergency treatment orders for psychotropic medication, pro re nata (PRN) orders, or standing orders. The psychiatric evaluation contained all the required elements. The psychiatrist documented the monitoring for Tardive Dyskinesia monthly for each of the three youth. A monthly Clinical Psychotropic Progress Note (CPPN) was completed for each of the three youth.

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

A review of the program's facility operating procedures (FOPs), exposure control plan, and contractual agreement revealed the program implemented infection control procedures. The procedures include prevention, containment, treatment, and reporting. The program's procedures contained all the required elements. The program provides education in universal precautions and hepatitis B immunizations to staff. There were no instances in which the local county health department, Centers for Disease Control and Prevention (CDC), or the Department's Central Communications Center (CCC) were notified of an infectious disease.

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

Seven staff training records were reviewed and each staff's training records documented training related in exposure control plan. Five youth individual healthcare records (IHCRs) were reviewed and each youth's IHCR documented training during orientation in infection control training. The training for both staff and youth contained all the required elements.

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

The program utilizes an exposure control plan in accordance with the Occupational Safety Health Administration standards OSHA (29 CFR 1910). All staff utilize the plan. The plan delineates procedures for a risk assessment, compliance, and needle stick post-exposure evaluation. There were no instances of exposure requiring notification of the local county health department or the Center for Disease Control and Prevention (CDC). According to the program director's interview, the program's exposure control plan is located in the administration office.

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

Five youth individual healthcare records (IHCRs) were reviewed. The program had one pregnant youth. The youth received a human immunodeficiency virus (HIV) test following counseling by the designated health authority (DHA). The DHA conducted a medical evaluation as well as utilizing the Women's Pregnancy Center and the Madison County Start Program. The youth interview determined the youth received prenatal, obstetrical, and gynecological services.

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

Five youth individual healthcare records (IHCRs) were reviewed. The program had one pregnant youth. Documentation of the pregnant youth revealed the youth was receiving nutritious food in quantities appropriate for a pregnant youth. A review of the program's facility operating procedures (FOPs) and related training revealed the youth received education on alcohol and drug usage, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care, birthing process, postpartum care, basic baby care , child/Infant development, and parenting skills.

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

Seven staff training records were reviewed and each non-healthcare staff received training in the treatment of pregnant youth. The training was provided by the licensed nurse.

Standard 5: Safety and Security

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

The program has a written policy and procedures requiring staff to maintain active supervision of youth, which includes 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).

During the annual compliance review, program staff were observed maintaining active supervision of youth and interacting positively with youth during all activities. Staff were engaged in a full schedule of constructive activities, while closely observing behavior of youth and changes in behavior, and consistently applying the program's BMS. Program staff were aware of the number of youth under their supervision at all times. The staff and youth were observed during groups, school, meals, and line movements, the staff-to-youth ratio was maintained, and head counts were concluded before and after every movement, and every time the youth crossed door thresholds. Formal counts were conducted every hour and informal counts were conducted every thirty minutes. If a count is unable to be reconciled, the program will stop all movement and conduct additional counts and search the facility, if necessary. The staff-to-youth ratio of one-to-eight during awake hours was observed. The staff-to-youth ratio is one-to-twelve during sleep hours.

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

The program has a policy and procedures in place concerning the behavior management system (BMS). The program has detailed written description of the collaborative BMS. The written description is posted in the program and included in the resident handbook for easy access and includes the rules governing conduct and positive and negative consequences for behavior including while in the classroom. The BMS policy is designed to foster accountability and compliance with the program rules and teach youth alternative prosocial methods of dealing with problems. The program has not made any changes to the BMS since the last annual compliance review. The BMS contains all of the required elements. A review of five individual youth records confirmed each youth reviewed and singed, acknowledging they received an orientation to the BMS upon admission to the program. Observations of the program confirmed the BMS was posted in the living areas of the dorm and in the class rooms. It is the program's

policy to provide a five-to-one positive-to-negative consequences. Five staff and five youth were interviewed concerning the BMS, each youth and staff were knowledgeable and had a clear understanding of the BMS system and were able to explain the BMS. According to the staff training roster, on June 7, 2018, the program conducted BMS training in which twenty staff participated. According to an interview with five staff, youth are rewarded with fun activities and events, which includes selecting items from the rewards cabinet and having movie nights. All five staff and the program director reported it is not the program's practice to take things away from the youth as consequences.

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

The program's behavior management system (BMS) is monitored by the program's supervisors, who are responsible for the implementation of the BMS and ensure the use of rewards and consequences are administered fairly and consistently. The program's BMS allows for staff explain to the youth the reason for any sanction imposed, the youth is given an opportunity to explain his or her behavior, and staff and the youth discuss the behavior's impact on others. Staff receive an annual performance evaluation on their implementation of the BMS. Room restriction is not utilized at the program; therefore, it is not a part of the BMS. The program's daily progress note system (DPNS) was reviewed. The DPNS is used to track each youth's progress in the program, behavior, interventions, level system, and point system. A daily progress report is generated, along with points which are displayed in the dorms. The points system and the progress report are used to provide daily feedback to youth concerning the BMS. According to the program director, the BMS is monitored in the performance evaluations, DPNS, and the shift supervisors are responsible for daily reviews of each youth in the DPN system.

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

The program has a policy and procedures requiring staff to observe youth at least every ten minutes while they are in their sleeping quarters, either during sleep time or during an illness. The program has twenty-six cameras to monitor the facility, all of which are operational. The program's video surveillance system stores video footage for up to sixty days. A review of ten-minute checks was conducted on three random days April 1, 2019, March 19, 2019, and February 14, 2019, between the hours of 12:00 a.m. and 3:00 a.m. The review of ten-minute

check confirmed the program completed the checks as required. The staff conducting the ten-minute checks were observed looking in each room and utilizing a flashlight to see the youth. It is the program's practice to radio to direct care staff to conduct ten-minute check. Ten-minute checks occur between eight and ten minutes randomly. Checks were documented in the logbook and on the ten-minute check sheet log in real time. Five staff were interviewed and each one was aware of the responsibility to conduct ten-minute checks.

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

The program has a policy and procedures to address census, counts, and tracking of youth. The program ensures each youth is always accounted for through a system of physically counting each youth at various times throughout the day. A review of the logbook and observations reviews revealed the program conducts and documents counts at the beginning of each shift, after each outdoor activity, during emergency situations, and when youth cross the threshold of doorways. Direct care staff revealed head counts are conducted every half hour and during each moment. According to staff interviews, if the count is not accurate, all movements are stopped, and a second head count is conducted after all the youth are gathered. If the count is not resolved, the Department's Central Communications Center (CCC) is notified, if needed.

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

The program has a policy and procedures requiring staff to maintain a chronological record of events, incidents, and activities in a central logbook maintained in the administration office, in accordance with Florida Administrative Code. A review of the logbook was conducted. The logbook is hardbound and in good condition and did not have any missing pages. Staff used ink for all entries and there were no entries removed through erasure, whiteout, or other methods. Entries included the date, time, description of the event, names of staff or youth, as appropriate, and the name and signature of the staff making the entry. The logbook documented staff received a briefing from the previous shift, as well as the incoming shift's review of the logbook and shift reports. The shift reports and logbook provided documentation of emergencies, youth

behavior incidents, counts, security checks, transports, admissions/releases, and escape incidents, as well as calls to the Department's Central Communications Center and/or the Florida Abuse Hotline. The program implemented a highlighter color code system to easily identify vital information.

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

The program has a policy and procedures in place governing the control and use of keys. The program's key inventory was reviewed and was found to match the keys in use. Three staff were checked for their personal keys and all of their keys were previously turned in and work keys were obtained. The master control operator was knowledgeable of the program's policy regarding key control and accountability. Staff interviews and observations revealed everyone entering the program must turn their personal keys and the keys are locked in a secured box located in the lobby of the program until they depart. In exchange for their keys, staff and visitors are given a chip which is used to identify their keys at the time of departure. Staff are only given keys matching their level of permissions/area of employment. If keys are missing, the program stops all movement, reports the incident to program leadership, and a search of the facility and youth is conducted. If keys are damaged, the supervisors are notified, and a maintenance request is made to replace the damaged key.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.* *The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the 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.*	

The program has a policy and procedures in place concerning contraband, which aligns with the Department's recommended guidelines. The policy defines what is considered contraband and details the methods to detecting contraband and preventing the introduction of contraband by

completing searches of the youth, physical plant, grounds, mail, and other areas. The policy clearly states staff discovered with contraband face disciplinary action, up to and including dismissal. The policy also states any illegal contraband discovered requires the notification of law enforcement authorities and the surrender of the contraband to the responding agency. The policy also addresses the documentation and disposition of non-illegal contraband. Youth are provided with a list of items considered contraband. A list of items considered to be contraband was observed to be posted throughout the program. The logbook documented regular and random searches of various areas, as detailed by policy. The program conducts random room searches daily, which results in each room being searched weekly.

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

The program has a policy and procedures requiring staff to perform searches to ensure no contraband is introduced into the facility. During the annual compliance review, multiple searches were observed. Searches were observed after recreation, after lunch and dinner, after school, and prior to movements. Prior to conducting the searches, staff explained the purpose of the search and instructed the youth to get in line for the search. Staff avoided using unnecessary force and youth were treated with dignity and respect to minimize the youth's stress and embarrassment. All searches were conducted by the appropriate number of staff and staff of the same gender. All five staff interviews revealed searches are conducted when youth return from off-campus, after school, prior to movements, and after meals. Youth interviews revealed searches are conducted after returning from off-campus, after outdoor activity, when items are missing, after visitation, and after meals, after work detail, and after all movement and leaving the bathroom.

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

The program has a policy and procedures ensuring all vehicles used to transport youth receive the appropriate maintenance and contain safety and emergency equipment to ensure they are operating in a safe manner. The program has three vehicles, two of which are used to transport youth. The remaining vehicle is not operational and not used to transport youth. The program ensures the two vehicles used for transporting youth are properly maintained, as well as maintaining documentation on the use and maintenance of each vehicle. Both vehicles received an annual safety inspection and are equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and an approved first aid kit. During the annual compliance review, the program implemented a new practice which requires staff to pick up a first aid kit along with the vehicle keys. This practice was implemented to ensure the first aid kits

are not left in the vehicles. It is the program's practice for each youth and staff to wear seat belts during transportation, and no youth can be attached to any part of the vehicle by any means other than the proper use of the seat belt. According to the assistant program director, the ratio for staff-to-youth during transport is one-to-five; however, the program always sends an extra staff for safety purposes.

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

The program has a policy and procedures concerning the ratio of staff to youth while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public. A random check of personal vehicles and facility vehicles was conducted, and all vehicles were locked when not in use except one personal vehicle. The open vehicle was immediately brought to the attention of the program director and the staff responsible immediately locked the door and was reminded to keep their vehicle doors locked at all times. It is the program's policy to meet the minimum ratio of one staff for every five youth during transportation; however, according the assistant program director, it is their practice to exceed the minimum requirement by providing an additional staff member on all transports. A review of staff records for staff who transport youth confirmed the program conducts monthly driver's license checks to ensure staff have a valid and current driver's license. An interview with the program director revealed staff do not use their personal vehicles to transport youth. Staff interviews revealed transporting staff are provided a cellular phone in case of an emergency. Staff also reported they are not allowed to use their personal vehicles for transporting youth.

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

The program has a policy and procedures in place requiring weekly safety and security audits. A review of the program's policy was conducted, and found the policy meets all of the requirements according to the Department. An interview with the program director revealed, there is a clear process regarding the identification and tracking deficiencies. This process requires staff to complete a maintenance request which will be addressed as soon as it its received and logged. The fence line is inspected by the assistant program director and the maintenance staff weekly. Tracking logs are used to track and verify deficiencies. Documentation was reviewed and confirmed the program is conducting the weekly safety and security audits, as required.

5.13 Tool Inventory and Management	Satisfactory Compliance
The facility shall have a tool management system ensuring youth do not use tools or equipment as weapons or security breaches.	

The program has a policy and procedures concerning tool management, which details the storage, inventory, issuance, and control of equipment and tools. The program maintains a log of all tools used at the program. Tools with sharp edges or points with a high potential to be used as a weapon are inventoried daily. The tools are stored in a shed on the program's

campus behind locked doors and the program uses a shadow outline to identify placement of tools. Tools are inventoried prior to being issued for work and after the work activity. Maintenance staff are required to sign tools in and out. Kitchen sharps are stored in a locked see-through container in the kitchen. The cleaning tools such as mops and brooms are stored in the closet and kept on a shadow board. During the program tour, all tools were observed securely stored behind locked doors and not accessible to youth. Tool inventories were reviewed and found to be accurate. Youth are only allowed to use the mop and broom to clean. Training records confirmed staff received the necessary training to safely operate tools.

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

The program has a policy and procedures concerning supervision requirements when youth are using tools. The policy details the supervision requirements, including ratios, issuance/collection of tools, and search requirements. Each youth utilizing tools receives an assessment and training prior to having access to tools. The staff-to-youth ratio is one-to-five during activities involving tools. Five youth were interviewed, and revealed they are only allowed to use rakes, scrub brushes, mops, and brooms. Video surveillance was reviewed of youth cleaning the gym and dorms; the review confirmed the staff-to-youth ratio was met, the youth were not handling chemicals, and youth were searched.

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

The program has a policy and procedures which establish guidelines for outside contractors, which includes information about tool control and restrictions. The program utilizes a signed agreement for each contractor visiting the program. The agreement acknowledges the policy and documents the tools introduced into the program. The program restricts tools to those necessary to complete the job requested. Tools are checked upon the worker's arrival and departure, and youth access to the work area is restricted. Contractor invoices were reviewed and compared to the signed agreements over the past six months. Each invoice contained the date and the services rendered. Each invoice matched the date identified on the sign-in sheet.

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

The program has a policy and procedures requiring the completion of fire, safety, evacuation, and disaster drills to ensure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster. Reviewed documentation revealed fire drills were conducted twice a month, one for each shift. Safety and evacuation drills are conducted monthly. Disaster drills are conducted every other month. The drill forms included all of the required elements, to include the type of drill, date, time, participants, brief scenarios, and the findings or recommendations. Five staff interviews confirmed the program conducted a variety of drills including fire, safety, evacuation, and disaster drills which includes but is not

limited to hostage situation and terrorism drills. Five youth interviews confirmed staff instruct youth on what to do in case of a fire.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature.	

The program has a coordinated disaster plan and Continuity of Operations Plan (COOP). The COOP provides 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 public. The plan was submitted and approved by the Department on April 1, 2019. The COOP included all of the required elements. Copies of the COOP are located in six different offices throughout the facility, including master control. An interview with the program director revealed the staff have access to the COOP.

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

The program has a policy and procedures concerning strict control of flammable, poisonous, and toxic items and materials and an inventory of all such items. Large volumes of chemicals are stored in a locked shed, which is inaccessible to youth. Chemicals for daily use are stored in a locked closet in a locked box, inaccessible to youth. A review of the inventory was compared with the actual inventoried items on-site. All chemicals matched the inventory supply. Only two staff have keys to the storage area, the program director and the building manager. The program provided documentation indicating Safety Data Sheets were completed as part of the inventory of each item.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program shall maintain strict control of flammable, poisonous, and toxic items and materials. *Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.*	

The program has a policy and procedures which prohibits youth handling and supervision for flammable, poisonous, and toxic items and materials. According to policy, youth do not handle any flammable, poisonous, and toxic items, materials or any of the cleaning chemicals maintained at the facility. Five youth were interviewed concerning the handling of chemicals. Two youth reported staff spray the cleaner and youth wipe it up. Two youth reported handling cleaning materials. The remaining youth reported handling glass cleaner, pine-sol, and other cleaners. Video footage was reviewed of youth cleaning the gym and dorms and confirmed the staff-to-youth ratio was met, the youth were not handling chemicals, and youth were searched.

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

The program has a policy and procedures concerning the disposal of flammable, toxic, caustic, and poisonous items. The maintenance manager is responsible for the oversight of the handling and disposing of hazardous waste and/or solid waste, hazardous items, and toxic materials. An interview with the maintenance manager revealed the program properly disposes of toxics, caustics, and poisonous items through agreements with Madison Recycle and Griffin Industries (GI). Madison Recycle is responsible for the disposal of the program's daily waste and GI is responsible for disposal of the program's kitchen grease. The agreements with Madison Recycle and GI are for weekly disposal of waste. All chemicals are used and disposed of utilizing the drainage system.

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

The program has a policy and procedures which promotes the active participation of youth through opportunities to make choices, assume meaningful roles, including team membership and leadership roles, and give input into the rules and operation of the residential community. The program activity schedule was available for review and posted throughout the facility. The weekday activity schedule revealed youth had scheduled recreation and leisure times for both indoor and outdoor activities for one hour daily. The weekend activity schedule revealed youth had scheduled leisure activities during two separate hours. The program has an assigned recreational therapist who ensures leisure activities are included in each youth's treatment plans. The recreational therapist has all required credentials. According to the recreational therapist, youth can voice their preference in recreational activities they would like to participate in each day by verbal requests, student council, or the suggestion box. Recreation and leisure activities include basketball, kickball, softball, cardiovascular exercises, stretching, drawing, letter writing, reading, and board games. All activities promote social and cognitive skills development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. During the annual compliance review, recreation was observed. Youth began recreation by stretching and conducting callisthenic exercises for warm up. The youth were observed in the gym playing baseball. A water cooler, with extra cups, was present during the entire recreation period. A review of the logbook reflected recreation and leisure activities were held in accordance with the daily activity schedule.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures in place allows visitation and communication for youth while in the program. The program's activity schedule specifies times for visitation, telephone calls, and letter writing. During the annual compliance review, visitation logs, telephone logs, mail correspondences, and schedules were reviewed, and confirmed youth are provided opportunities to communicate with their family daily. Logs notate the time the telephone call begins/ends, who the telephone call was with, and both staff and youth initial the log. The program maintains a list of approved family relatives the youth are allowed to communicate with. According to the program director, the program will make special accommodations for a parent/guardian who cannot visit during the scheduled visitation time. The program accommodates parents/guardians with special telephone time in the event work

schedules or other extenuating circumstances prevent telephone calls from taking place at the scheduled times.

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

The program does not utilize controlled observations; therefore, this indicator rates as non-applicable.

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

The program does not utilize controlled observations; therefore, this indicator rates as non-applicable.

5.26 Controlled Observation Safety Checks Release Procedures	Non-Applicable
The program shall conduct safety checks for youth on Controlled Observation. The 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 observations; therefore, this indicator rates as non-applicable.

Program Name: JoAnn Bridges Academy
Provider Name: Rite of Passage, Inc.
Location: Madison County / Circuit 3
Review Date(s): April 2-5, 2019

MQI Program Code: 1444
Contract Number: 10361
Number of Beds: 28
Lead Reviewer Code: 127

Overall Rating Summary

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