STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Juvenile Unit for Specialized Treatment (JUST)
Twin Oaks Juvenile Development, Inc
(Contract Provider)
29841 Liberty Wilderness Road
Sumatra, Florida 32335

Review Date(s): May 13-17,2019

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:

Juan D.Youman, Office of Program Accountability, Lead Reviewer ([Standard])
Jill Foy, Office of Program Accountability, Regional Monitor (Standard 3)
Tara Frazier, Office of Program Accountability, Regional Monitor (Standard 4)
Derrick Henderson, DJJ Probation, Circuit 14, Senior Juvenile Probation Officer (Standard 2)
Sara Hollar, Office Programming and Technical Assistance, Government Operations Consultants II (SPEP and Interviews)
Micah Youmas, Leon Regional Detention Center, Sergeant (Standard 5)

Program Name: Juvenile Unit for Specialized Treatment
Provider Name: Twin Oaks Juvenile Development, Inc
Location: Liberty County / Circuit 2
Review Date(s): May 14-17,2019

MQI Program Code: 1086
Contract Number: R2105
Number of Beds: 32
Lead Reviewer Code: 141

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
- **N/A** # Case Managers
- **1** # Clinical Staff
- **0** # Food Service Personnel
- **1** # Healthcare Staff
- **N/A** # Maintenance Personnel
- **1** # Program Supervisors
- **3** # Staff
- **3** # 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
- **7** # Health Records
- **7** # MH/SA Records
- _____ # Personnel Records
- **14** # Training Records/CORE
- **3** # Youth Records (Closed)
- **7** # 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	Non-Applicable
1.05	* Incident Reporting (CCC)	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Non-Applicable
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	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	*Ten Minute Checks	Non-Applicable
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	Satisfactory
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 Juvenile Unit for Specialized Treatment program is a thirty-two bed program, for thirteen to seventeen year old males, located in Hosford, Florida. The program is operated by Twin Oaks Juvenile Development, Inc, through a contract with the Department.

The program provides intensive mental health services to youth in the program. In addition, the program fosters each youth by providing Impact of Crime, Thinking for a Change, and Life Skills. Additional services provided include the Boys and Girls Club and the opportunity to complete community service hours.

Program administration is comprised of a program director, assistant program director, and a training coordinator. Case management services are provided by four case managers. Mental health staff at the program includes a psychiatrist who serves as the program's designated mental health clinician authority (DMHCA), a licensed mental health counselor, a behavior specialist, four behavioral technicians, and four counselors. The program also has one recreational therapist and a transition specialist. Medical services are offered daily and are provided by a medical doctor who serves as the designated health authority (DHA), two registered nurses (RN), and two license practical nurses (LPN). The program also uses the Liberty County Health Department for medical services. Educational services are provided by the program. The program has one lead teacher, three teachers, and two vocational instructors.

The layout of the program includes the main building which consists of administrative offices, case management and mental health staff offices. One classroom and teacher office were located in another building on-site. The program also has a dining facility and a GED classroom located in another building. The program has a medical clinic, and four dormitories. The program does not have any operating security cameras providing coverage. The program is surrounded by the Apalachicola National Forest with no fencing.

At the time of the annual compliance review, the program had no vacant positions. The program has an extensive vocational program with interests in carpentry and welding.

The program utilizes the Apalachicola Forrest Youth Camp (AFYC) to prepare all the meals for the program. All dietary needs and nutrition is supplied by AFYC.

Strengths and Innovative Approaches

The program has a hog pen for raising pigs, a gated in garden on approximately one acre, a new aquaponics system, and two ponds.

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.	

A review of the staff roster found nine staff who required an initial background screening. The program utilizes the Agency for Healthcare Administration (AHCA) Clearinghouse for background screening. None of the staff were hired prior to receiving an eligible background screening. Each background screening report was found in the staff's personnel record and the staff were included on the program's Clearinghouse employment roster. Each record contained a pre-employment assessment tool administered to direct care applicants with each staff receiving a passing score. The program did not have any volunteers, mentors, or interns who assisted or interacted with the youth on an intermitted basis for more than ten hours a month.

The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit (BSU) prior to January 02, 2019.

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

The program has a written policy and procedures in place regarding the completion of background rescreenings for staff, volunteers, mentors, and interns who have been with the program for five years. Rescreenings are completed prior to their five year anniversary date. A review of the program's staff roster found the program did not have any staff, volunteers, or interns who required a five-year background 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.*

A review of nine staff records found each contained a signed code of conduct form which identified expectations for ethical and professional behavior. All youth and staff are required to report all cases, even suspicion of abuse according to the program's policy. All youth and staff have unhindered access to report allegations of abuse. Youth are never denied a call to the Florida Abuse Hotline. The program has not had any instances of abuse. The Florida Abuse Hotline and Central Communications Center (CCC) contact numbers were posted throughout the program.

The program reports each youth is made aware of their right to report abuse during orientation and staff through training. When a youth request to make a call to the Florida Abuse Hotline, both the supervisor and program director are notified of the call. With no response necessary, the staff dials the number for the youth and then allow the youth to report the alleged abuse incident. The program director revealed staff are not to be mentally or physically abusive to youth. All abuse allegations are reported immediately. All substantiated incidents of abuse will result in staff termination.

Three interviewed youth reported they feel safe at the program. The same three youth reported they have never been stopped from reporting abuse to the Florida Abuse Hotline or CCC since they have been at the program. Each of the three youth reported staff are respectful when talking with them and other youth. Two of the youth reported hearing staff use curse words when speaking with youth occasionally and one youth reported often. Three interviewed staff revealed they have never observed a co-worker telling a youth they could not call the Florida Abuse Hotline. Staff interviews also revealed they have never observed a co-worker using profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth.

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

The program had no instances of physical, psychological, or emotional abuse in the program during the annual compliance review period; therefore, this indicator rates as non-applicable.

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

The program had a total of fifteen incidents reported to the Central Communications Center (CCC) in the last six months. A random selection of five reports were reviewed. Each incident was reported to the CCC within the required two-hour timeframe. Each incident was documented in the facility logbook. A review of the program's internal incidents and grievances found there were no additional incidents which were required to be reported to CCC. The program has not experienced an increase in CCC reports since the last annual compliance review. Program director revealed the supervisors notify the CCC of any incidents, along with the program director and Department personnel.

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's Protective Action Response (PAR) plan was approved by the Department on February 2, 2019.The program had one PAR report for review. The report was completed by the end of the staff member's work day and included all statements from staff involved. The report was reviewed by a PAR certified instructor. The Post-PAR interview was conducted with the youth by the administrator or designee within thirty minutes of the incident. The report was reviewed by the program director within seventy-two hours of the incident excluding weekends and holidays. The program's PAR rate during the annual compliance review period was 0.24, which is below the statewide Residential PAR rate of 1.51. The program director revealed the process for monitoring PAR incidents and use of force consist of a four-hour review being conducted after each incident with staff involved, program director, assistant director, supervisor, and training officer on duty.

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.	

A review of seven staff training records found each of the staff completed the required 120 hours of pre-service training within 180 days of hire. Each staff completed training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, child abuse reporting, emergency procedures, suicide prevention, and Prison Rape Elimination Act (PREA). Each of the trainings were documented in the Department's Learning Management System (SkillPro). A list of pre-service training was submitted and approved by the Office of Staff Development and Training which included course names, descriptions, objections, and training for any instructor-led training on April 10, 2019.

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.*	

A review of seven staff training records found each staff completed all required in-service training hours. Two of the staff training records reviewed were for supervisory staff. As a part of the in-service training requirements, the supervisors completed eight hours of training in management, leadership, personal accountability, employee relations, and fiscal. All of the licensed nursing staff had a current certification in cardiopulmonary resuscitation (CPR) with automated external defibrillator (AED). Each training was documented in the Department's Learning Management System (SkillPro). The program has an annual in-service training calendar which is updated as changes occur. A review of the training records found all instructors were qualified to deliver trainings provided. The program submitted, in writing, a list of in-service training to the Office of Staff Development and Training which included course names, descriptions, objections, and training for any instructor-led training on April 10, 2019. The plan was approved on the same date.

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 grievance process which includes three phases. There is an informal, formal, and appeal phase. The informal phase gives the youth and the staff and opportunity to discuss the grievance. If the youth is not satisfied with the results, they can appeal to the supervisor in the formal phase. The final phase is the appeal phase in which the director or designee meets with the youth and come up with a final solution. All grievances are maintained

in the program's grievance binder. The program has not had any grievances since the last annual compliance review.

Three interviewed staff and three interviewed youth reported they understood the program's grievance procedures. Each were very knowledgeable in the grievance procedures. The youth stated they could ask for assistance when completing a grievance form. The program director explained the grievance process as the youth writes a grievance and turns it into staff. The staff then attempts to resolve the grievance with the youth. If it is not resolved, the supervisor is given the grievance in an attempt to resolve it. If necessary, the program director or assistant program director will resolve the grievance.

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.	

Two staff are trained to deliver the program's delinquency intervention model. Each youth at the program participates in Impact of Crime (IOC) and Thinking for a Change (T4C). Both curriculums are evidence-based practices. Each facilitator completed all required training for IOC and T4C. The program director revealed youth are matched to staff and are mindful of any staff history with youth in a further attempt to ensure appropriate service delivery. The staff facilitators work in accordance with the program's contract and guidelines. A review of group sign-in sheets validated both courses were provided, as required. A review of youth records found each of the youth were participating in IOC and each of their performance plans included IOC as a goal. The program offers an array of structured, planned programming, and activities for at least sixty percent of the day, as indicated on the program activity schedule. Three youth were interviewed and each reported they participate in IOC and T4C.

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 activity schedule includes and Life Skills Training (LST) for youth. T4C and LST are provided twice a week for one hour each session, on Tuesdays and Thursdays. The program utilizes two facilitators. The program's therapists facilitate the curriculums. A review of training records found each facilitator completed training in the curriculums. A review of seven youth records found each of the youth were participating in groups, as outlined in their treatment plans. Sign-in sheets mirrored the program's activity schedule. The program director reported LST is delivered every week by the mental health staff.

Three interviewed youth indicated they have participated in LST while at the program and were able to describe new skills or behaviors they have been taught.

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 utilizes the Impact of Crime (IOC) curriculum to provide restorative justice awareness to the youth. The curriculum allows for youth to have an opportunity to feel what it is like to be the victim of a crime and learn to empathize with victims. Community service projects are utilized as well.

IOC is held twice a week for one hour, as evidenced by a review of sign-in sheets and the activity schedule. A review of staff training records indicated one staff is trained to facilitate IOC. Observations of an IOC group provided insight on how the groups are conducted, as the youth were able to describe what the victim's experiences. The program director reported youth attend IOC twice a week. All youth can earn at least sixty hours of community service and work with Department of Transportation (DOT) to pay back what they owe in court cost and restitution. Three interviewed youth reported they can demonstrate the skills they learned while in group.

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

The program provides gender-specific programing twice a week to all the youth at the program. During orientation, the nurse provides hygiene and male self-examination education. The registered nurse is trained to provide the services to the youth. The Liberty County Health Department offers male sexually transmitted disease screenings, education, and counselling. Boys and Girls Club provided gender-specific education and topics to the youth at the program. A review of sign-in sheets found groups were delivered, as listed on the activity schedule. The program director revealed the program uses Boys and Girls Club activities as gender-specific programming.

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 utilizes both an internal alert system and the Department's Juvenile Justice Information System (JJIS). The program's written policy and procedures outline how alerts are identified, documented, updated, and communicated to staff. A review of the internal alert system found it was consistent with the alerts which were entered in JJIS. The program director

revealed mental health staff are responsible for making updates to mental health and substance abuse alerts and medical staff are responsible for making updates to medical alerts.

Seven internal alerts were reviewed and were found to be consistent with the JJIS alerts. Four of the seven alerts required a youth's status to be downgraded, which was completed by the program's licensed mental health professional downgraded each the four applicable alerts. The program director reported the program's alert process begins at intake for the youth. The program also utilizes an alert list available to each staff. Alerts are also discussed during shift change.

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 a separate individual management record, mental health/substance abuse record, and an individual healthcare record for each youth. All records were clearly labeled "confidential." The file tab for each record included the youth's name, Department identification number, date of birth, county of residence, and committing offence. The sections in the individual management record were labeled as legal information, demographic and chronological information, correspondence, home visits, prescreening administration, orientation, admission classification, letters of consent, assessments, and miscellaneous. Records are secured in a locked file cabinet also labeled "confidential," located in a locked room case management room.

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

The program's formal process for youth input occurs quarterly. The program utilizes the Boys and Girls Club and the advisory board meetings to host the discussions. Based on a review of sign-in sheets, the program holds meetings for youth input quarterly. Sign-in sheets highlight the youth's name and dates meeting were conducted. Documentation also included what the youth would like to discuss and the staff's response.

Three interviewed youth reported the program does not have a process allowing youth to provide input about what happens at the program. The program director revealed the program does have a process for youth to provide input. Request forms are available for youth to provide constructive input for the program.

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 meets at least quarterly. There was documentation of the program soliciting active involvement from the local community to include law enforcement, judiciary, business community, school board or district, faith community. The program director also recruits victims, victim advocates, or other victim services community

representatives, and a parent/guardian whose child was previously involved in the juvenile justice system.

The program maintains documentation for all advisory board meetings. There was documentation indicating the program held advisory board meetings each quarter. Attendee members included all appropriate members of the community with the exception of judiciary staff. The program has documentation of soliciting a judge but has not found one able to attend as of the date of this annual compliance review. The program maintains a roster for all attendees. The roster included the names, titles, and contact information for all attendees. A review of the detailed minutes from the advisory board meetings found documentation of each meeting, participants, and a review of ideas. The program provides lunch from their dietary department.

The program director reported the advisory board meets quarterly and the board members are involved with all aspects of the program. The program director also reported the board helps with community resources and obtain needed and support services. A board member was not available for interview during the annual compliance review week.

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

The program has a policy and procedures are for facility integration and stability. The policy establishes a system for staff to be involved in communicating issues, staff evaluations, and staff retention. Staff communication is accomplished during meetings, conference calls, the internal alert system, and shift reports. Recruitment and retention includes utilizing a TRENDSTAT process and quality improvement initiative. Recruitment efforts are used through One Stop Career Center, job fairs, and local advertisements. The program director reported the program meets on quarterly basis. Sign-in sheets clearly captured the dates and times of the meetings.

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

The program has a policy and procedures which delineates the staff's performance process. The program policy ensures a system for effective communication, annual evaluation, and staff retention. The objective is to inform management and the staff of their job performance.

A review of three direct care personnel records found each record included a staff performance review form. The form included a rating scale and overall rating scale, job knowledge, quality of work, ability, initiative, flexibility, professionalism, compliance, training, documentation/reporting, and leadership. Each staff had an annual evaluation. Each evaluation was signed and maintained in the staff record.

Position descriptions included a position summary, essential functions, working conditions, physical requirements, and acknowledgement. The program director reported each staff receives an evaluation and the evaluations are maintained in the staff's records.

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.	

Seven case management records were reviewed and at the time of admission into the program, each youth's parent/guardian was contacted by telephone and written notification was sent within forty-eight hours of the youth's admission. Additionally, the committing courts, assigned juvenile probation officers (JPO) and post-residential services counselor (if applicable) received notification in writing within five working days of the youth's admission.

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

In review of seven case management records, there was clear documentation to support the youth were oriented into the program within twenty-four hours of admission. Each record contained an orientation checklist to ensure all portions of the orientation was addressed. All youth were given a student handbook upon admission. Three youth were interviewed, and all stated they were provided an orientation within twenty-four hours of admission.

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.	

A review of seven case management records found four of the seven were for youth ages eighteen or older. Each record indicated the program obtained written consent from the youth to discuss physical or mental health screenings, assessments, and/or treatment with the parent/guardian.

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

The program utilizes a classification system in place to promote safety and security and effective delivery of treatment services. The program uses a classification form detailing factors such as the youth's physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, and identified risk factors. The program utilizes an internal alert system documenting any medical, mental health, security risks, or special needs identified during the initial classification process or identified throughout the youth stay at the program. An interview with the program director indicated at the time of admission, prior to youth being assessed or reassessed, the youth's physical health status, cognitive performance, age, and prior victimization are considered when assigning a youth to a living unit and/or sleeping room. A review of seven youth records found each contained a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment.

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

The program has a written policy and procedures which address gang identification and the notification to law enforcement, prevention and intervention activities. The program has a zero tolerance for gang related behavior. Seven youth case management records were reviewed. All seven youth received a Gang Assessment upon admission. One of the seven records reviewed was applicable for gang identification; therefore, additional records were requested. The only additional applicable record was provided for review. There was documentation indicating local law enforcement was notified of suspected gang involvement for each youth. During the facility tour, there was no evidence of gang graffiti or youth wearing gang clothing. The program has designated the assistant program director as the gang liaison. The program's policy indicates a youth's assigned case manager will report any gang-related information to the Florida Department of Law Enforcement (FDLE) directly to the program director.

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 written policy and procedures which addresses gang identification and notification to law enforcement and prevention and intervention activities. A review of seven youth records found one youth applicable for gang association. The program provided the only one additional applicable record for review. The program utilizes the Impact of Crime (IOC) curriculum as their gang intervention strategy. Both youth are currently participating in Impact of Crime classes, which was also included on the youth's performance plans.

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.	

Seven youth case management records were reviewed. Six records indicated each youth was assessed using the Residential Positive Achievement Change Tool (R-PACT), completed within thirty days of admission and were maintained in the Department's Juvenile Justice Information System (JJIS). One of the youth was assessed using the Residential Assessment of Youth (RAY), which is the Department's newest assessment instrument. Five of the seven reviewed case management records were applicable for R-PACT reassessments. The five case management records had documentation of an R-PACT reassessment which was also documented in JJIS. The reassessments were conducted within ninety days of the initial R-PACT, as outlined in program policy.

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 seven youth case management records was conducted for verification of the Youth Needs Assessment Summary (YNAS). There was documentation each YNAS was completed within thirty days of admission. Each YNAS was documented in the Department's Juvenile Justice Information System (JJIS) and in the 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.*	

A review of seven case management records was conducted. All records had an initial performance plan developed within thirty days of admission. There is documentation each member of the treatment team was present during the development of the initial performance plan for each youth. Each of the three interviewed youth stated they participated in the development of their initial performance plan. The performance plans were individualized and prioritized needs reflecting the risk and protective factors identified during the initial assessment process. The individualized performance plan targeted measurable outcomes, decreases in criminogenic risk factors and promote strengths, skills, and supports to reduce the likelihood of the youth reoffending. The plans targeted the top three criminogenic needs and addressed and contained transition activities for the last sixty days of the youth's stay. Of the seven records, four of the youth had target court-ordered sanctions the youth could complete while in program identified on the performance plan. Each individualized performance plan covered staff and youth responsibilities and included target dates for completion of goals prior to release of the program. All three interviewed youth stated they knew their performance plan goals. There was documentation in all seven records of the performance plans being sent to the committing court within ten days of completion. The treatment team leader, as well as other members, signed the performance plans indicating acknowledgement of its contents and associated responsibilities. The original performance plans were signed and placed in the case management records. All of the interviewed youth stated they received a copy of their performance plan.

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

The program has a written policy and procedures in place regarding revisions to a youth's performance plan. Five of the seven youth records were applicable for performance plan revisions. Each of the five records contained documentation of a performance plan revision. Each revision reflected the R-PACT reassessment results, newly acquired/revealed information, and progress and/or lack of progress towards completion of the youth's performance plan goals.

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.*	

Six of the seven youth case management records were applicable for performance summaries and transmittals. The remaining youth had not yet been at the program long enough to require a performance summary. Summaries were completed every ninety-days following the signing of the performance plan. Six of the seven records included documentation of the youth's status on each performance plan goal and overall treatment progress. All six records included progress updates which included academic status, behavior, level of motivation and readiness to change, interaction with peers and staff, overall adjustment to the program, significant positive and negative events, and justification for release (if applicable). In all applicable records reviewed, youth could read and add comments prior to signing the summaries. All records included the original summary, and indicated the youth received copies of their summaries. In all six youth records reviewed, the performance summaries were signed by all required parties. Copies of summaries were sent to the committing court, the assigned juvenile probation officer, youth, parent/guardian. None of the six records required a summary to be sent to a Department of Children and Families caseworker. Three closed records were reviewed for release summary contents. In all three closed records, an original summary, along with justification for release and the Pre-Release Notification, were sent to the assigned juvenile probation officer at least forty-five days prior to the youth's planned release. Signed copies of the summaries were retained in each of the records reviewed. The Exit R-PACT was included in each applicable record reviewed. None of the records reviewed required victim notification for youth who were determined to be required for Sexually Violent Predator Program.

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 provides opportunities for each youth's parent/guardian to participate in the treatment and case management services provided. The program has an assessment process for the parent/guardian to complete. The program provides parent/guardian surveys, which the results are shared with administration and submitted to corporate office for compilation in a quarterly report. Observations of the treatment team and performance planning process were made during the annual compliance review. The parent/guardian was contacted during the treatment team meetings. Prior to formal treatment team meetings and transitional conferences, parents/guardians are given advanced notice of meeting dates and times. Parents/guardians can participate by telephone, if unable to visit in person. A review of the program's contractual agreement found evidence performance expectations were being met related to parent/guardian involvement. The program director was interviewed and stated upon entrance to the program, the case manager contacts the parent/guardian through an introductory letter, as well as by phone to advise of the process their child will be going through while in the program. They are

informed of the treatment team schedule and visitation times and are invited to be actively involved in the process. Three interviewed youth confirmed their parents/guardians were involved in the treatment planning process, and they make regular contact with family through mail or telephone.

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.	

A review of seven youth case management records found each youth is part of a multidisciplinary treatment team. Upon admission to the program, during orientation, the youth is introduced to treatment team members. Treatment team members included the youth, an administration representative, a living unit representative, educational staff, treatment staff, facility gang prevention specialist when applicable, medical staff, recreational therapist and case management staff. The case manager assigned, serves as the treatment team leader Documentation reviewed indicated parents/guardians and juvenile probation officers (JPO) were invited to participate in treatment team meetings.

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

Seven youth individual management records were reviewed for incorporation of other plans into the performance plan. All seven youth records included an academic plan which referenced the youth's education while at the program. All seven records also referenced the youth's mental health and/or substance abuse treatment plan. Recreational therapeutic activities were also incorporated into the plans observed. None of the reviewed records were applicable for requiring a case plan through the Department of Children and Families and/or Agency for Persons with Disabilities.

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 written policy and procedures in place regarding formal and informal treatment team meeting reviews. The policy clearly states the formal treatment team meetings occur every thirty days, while informal treatment team meetings occur on a bi-weekly basis with the youth and case manager. Seven case management records were reviewed to ensure formal

and informal reviews were completed within the required timeframes, and necessary documentation was captured in the case management record. The informal performance reviews were held within appropriate time frames and were documented in the case management records to include the youth's name, date of review, meeting attendees, pertinent information from the treatment team, a brief overview of the youth's progress as it relates to treatment, and Residential Positive Achievement Change Tool (R-PACT) reassessment results. A review of seven youth case management records confirmed treatment team formal reviews were conducted at least every thirty days. Formal treatment team meetings were documented in the case management record and included the youth's name, date of review, meeting attendees, comments from treatment team members, a summary of the youth's progress in the program, and any performance plan revisions. All three interviewed youth stated they were provided an opportunity, during treatment team meetings, to demonstrate skills learned in the program. There was documentation in all of the youth records indicating the youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were invited and encouraged to participate in the treatment team meetings. All interviewed youth stated they could demonstrate skills learned in program. During the annual compliance review, there were two treatment team meetings observed and at the meetings, the following individuals were present or participated by telephone: JPO, representative from administration, parent/guardian, medical, school, recreational therapist, mental health therapist, and direct care staff. The educational representative discussed progress on each youth's performance plan, positive and negative behaviors, and the youth were able to discuss and demonstrate skills acquired in the program. All team members actively participated in the treatment planning process.

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

Three closed youth case management records were reviewed for career education. The three records contained employability as part of the performance plan. The following elements were part of the case management records: a sample completed employment application, schedule which will identify an appointment with Career Source Center, social security card, birth certificate, Florida identification card, and documentation which the post-residential counselor, as well as parent/guardian are aware of the employment plans. The program utilizes My Career Shines as an assessment tool when the youth is admitted into the program. The two vocational classes offered at the program are building construction and welding. According to information received during an interview with the program administrator, the program provides Type III vocational aptitude development programming including the National Center for Construction Education and Research (NCCER) certifications in carpentry and welding. In addition to welding and carpentry, SafeServ certifications are also offered to the youth. The vocational programs provided are appropriate for the age of the youth, educational abilities and goals of the youth, and typical timeframe for the length of stay. The career education programming provided by the program includes communication, interpersonal skills, and decision-making skills. The youth at the program are able to participate in the Boys and Girls Club.

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

The program has a policy and procedures in place to ensure youth have access to educational services. The lead teacher provided documentation to support the current school year calendar which accounts for 250 days of instruction and ten days for planning and training. The daily bell schedule for the program lists 300 minutes of instruction with five fifty-minute classes. The lead teacher did not indicate concerns in her interview about the school schedule. According to youth interviews there were no issues with interference of education instruction. The logbook was reviewed and education classes were taking place as scheduled with minimal interference of educational instruction.

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

Three closed case management records were reviewed for education transition plans. Each record had an individual education transition plan, developed based on the youth's post release goals, beginning at admission. Each plan included services and interventions, based on the youth's evaluated educational needs, and post-release education plans and services to be provided during the program stay, and services to be implemented upon release. An interview with the lead teacher revealed standardized tests and assessments in reading and math are used in the youth's transitional planning.

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

A review of three closed youth case management records found transitional conferences were held sixty days prior to the youth's release date. The youth, treatment team leader, program director/designee, juvenile probation officer (JPO), educational staff, and parent/guardian were members of the transition team. A review of the sign-in sheets confirmed participation in transition planning and conference. There was documentation in each youth's record showing invitations were sent to the youth's JPO, parent/guardian, and education staff, encouraging

participation and input in the youth's transition planning conference. All three closed case management records found evidence of completed Community Re-Entry Team (CRT) meetings. All three CRT meetings included participation by the case manager and were held prior to the youth's release.

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

Three closed case management records were reviewed for exit portfolios. The three records contained copies of the state-issued identification card, youth's transition plan, calendar with dates, times, and location of follow-up appointments. The exit portfolio also contained the Social Security Card, birth certificate, and vocational certificate(s) earned in the program. The records included school transcripts, resumes, and a completed sample job applications. There was documentation of the youth's exit portfolio being completed, and forwarded to the juvenile probation officer, and given to the youth upon release.

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

Three closed case management records were reviewed for exit conferences. The exit staffing was conducted at least fourteen days prior to departure. The case management records contained clear documentation to include the dates, signatures, and a summary pending transition goals. The date of the admission and termination from program correlated with the said information in the Department's Juvenile Justice Information System. The following individuals participated in the exit staffing: parent/guardian, treatment team leader, educational representative, juvenile probation officer, and youth. The documentation further revealed all required parties participated in the exit conferences, and all documentation was present in each record. The Community Re-Entry Team meeting, transition meeting, and exit meeting were all conducted on different occasions, as indicated in the three closed case management records.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a written policy and procedures ensuring there is a mental health professional identified by the program in writing, who oversees the delivery of mental health and substance abuse services. The program's designated mental health clinician authority (DMHCA) is a licensed psychiatrist under Chapter 458. The DMHCA is on-site every Sunday for four hours. Sign-in sheets were available for review and reflected weekly visits by the DMHCA. The DMHCA's schedule reflects sufficient time to ensure appropriate coordination and implementation of mental health and substance abuse services is taking place. A review of the DMHCA's license determined it is clear and active, expiring on January 31, 2020. The program also provided the agreement with the psychiatrist, as well as a position description. The program's clinical director is a licensed mental health counselor (LMHC) with training in mental health and substance abuse coordination. Position descriptions of all mental health staff, licensed and non-licensed, were provided by the program. The DMHCA reported he assesses each youth initially and provides all psychiatric treatment, follow up, medication management, and ensures service delivery.

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

The program's clinical director is a licensed mental health counselor (LMHC). A review of the clinical director's license reflected an expiration date of March 31, 2021. The licensed mental health and substance abuse clinical staffing is in accordance with the current contract and Rule 63N-1, F.A.C. The clinical director is the only licensed therapist employed with the program. The clinical director ensures all clinical staff members working under their supervision are performing services the staff members are qualified to provide based on the staff's education, training, and experience.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory Compliance
The 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 clinical director assures the non-licensed staff working under their supervision are performing services they are qualified to provide based on the education, training, and experience. The clinical director supervises three non-licensed clinical staff members. The non-licensed mental health and substance abuse clinical staff is in accordance with the current contract and Rule 63N-1, F.A.C. Non-licensed mental health and substance abuse clinical staff receive one hour each week of on-site face-to-face direct supervision by the licensed clinical director. A review of the supervision log reflected direct supervision is conducted individually, each week, for all three non-licensed mental health staff members. The supervision log was observed to be documented on the MHSA 019 form. Education records for each non-licensed staff member was reviewed and reflected appropriate degrees were obtained. Two of the three non-licensed staff members hold master's degrees in area of counseling, social work, or psychology, while the third staff member holds a bachelor's degree in the field of counseling and has completed fifty-two hours of pre-service training, as described in Rule 63N-1 F.A.C, prior to working with youth. The program is licensed under Chapter 397, to provide substance abuse treatment services. All non-licensed staff providing substance abuse services received training in accordance with Rule 65D-30 F.A.C. All three non-licensed mental health staff who conduct Assessment of Suicide Risks (ASR) received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency health services. The clinical director is responsible for reviewing and signing Comprehensive Mental Health Evaluations, updated Comprehensive Mental Health Evaluations, Initial Mental Health Treatment Plans, Substance Abuse Evaluations, Substance Abuse Treatment Plans, and Individualized Treatment Plan prepared by non-licensed staff within ten calendar days of administration of the instrument. Additionally, the clinical director reviews any ASR or follow-up ASR completed by non-licensed staff within twenty-four hours of the assessments.

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

The program has a written policy and procedures to ensure the mental health and substance abuse needs of youth are identified through a comprehensive screening process which ensure referrals are made when a youth has a mental health or substance abuse need. Seven youth mental health records were reviewed. Documentation in all seven records reflected a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) was completed on the day of admission for each youth. According to the written policy and procedures, all youth receive a MAYSI-2, as well as an Assessment of Suicide Risk (ASR) upon admission to the program. Documentation in all seven records reflected an ASR was completed on each youth regardless of the results of the MAYSI-2. Documentation reflected staff reviewed available information to include the commitment packet, reports and records for existing documentation of mental health or substance abuse problems. The program's practice is to refer each youth for a substance abuse assessment, regardless of the results of the MAYSI-2. Each of the records

contained a substance abuse evaluation. Documentation further reflected the clinical director and program director reviewed and signed all results of the MAYSI-2 and ASR. The program's written policy and procedures are developed by the program director and address the following: standardized screening process which includes the review of the commitment packet, administration of the MAYSI-2 by a "qualified professional," and referrals are made for youth as necessary. Clinical staff completed training in the administration of the MAYSI-2. The program has a standardized process for referral of youth identified as in need of further assessment, or when immediate attention is needed, to a hospital or Baker Act or Marchman Act receiving facility. According to the program director, the MAYSI-2 and ASR are used to identify youth who are 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.	

The program has a written policy and procedures which establish a written mental health and substance abuse plan ensuring the mental health and/or substance abuse needs of the youth are identified through a comprehensive mental health and substance abuse evaluation process. The program's practice is to complete a comprehensive mental health evaluation and substance abuse evaluation for each youth admitted to the program. Seven youth mental health records were reviewed for a comprehensive mental health evaluation. Seven of seven records contained a new comprehensive mental health evaluation completed within thirty days of the youth's admission to the program. Three of the seven comprehensive mental health evaluations were completed by the clinical director, who is licensed. Four of the seven were completed by non-licensed staff and reviewed by the clinical director on the same day or within twenty-four hours of completion. Each of the new evaluations included the following: demographics, reason for evaluation, relevant background information, behavioral observations, mental status examinations, interview, discussion of findings, diagnostic impression, and recommendations. Seven youth records were reviewed for a comprehensive substance abuse evaluation. Seven of seven records reviewed contained a new substance abuse evaluation completed within thirty calendar days of admission to the program. The substance abuse assessments were completed under the program's licensure; Chapter 397. Each of the seven substance abuse assessments included the following: reason for assessment, relevant background information, behavioral observations, methods of assessment, patterns of drug and alcohol abuse, impact of drug and alcohol abuse on major life areas, risk factors, clinical impression, recommendations, and original referral reason.

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

The program has a written policy and procedures to ensure mental health and substance abuse treatment is guided by an individualized treatment plan which addresses all of the youth's

needs. Seven youth mental health records were reviewed for mental health and substance abuse treatment. Documentation reflected all seven youth were assigned to a multidisciplinary treatment team upon admission to the program. The multidisciplinary treatment team was observed to be comprised of the following: youth, program administration, residential living unit, and staff responsible for delinquency intervention and treatment services for youth. Documentation reflected the treatment team was also comprised of representatives from the following areas: education, vocational training, medical staff, and the youth's parent/guardian, when possible. Seven of seven reviewed youth records reflected the youth are participating in both mental health and substance abuse treatment. Each of the seven youth records contained a properly executed Authority for Evaluation and Treatment (AET). All seven youth receiving mental health and substance abuse treatment were all observed to have a mental health and substance abuse related diagnosis. Each of the youth receiving substance abuse treatment had a signed Substance Abuse Consent and Release form in their record. Mental treatment notes were observed to be documented on the Counseling/Therapy Progress Note form in each of the seven youth's records. A review of group therapy sign-in sheets reflected groups are limited to ten or fewer youth for mental health treatment groups. A review of sign-in sheets for substance abuse groups reflected groups are limited to fifteen or fewer youth at a time. All seven youth were receiving individual psychotherapy or counseling (one-to-one) as prescribed within their individual treatment plans. Each of the youth were receiving psychosocial skills training specifically addressing symptoms or maladaptive behaviors addressed within their individual treatment plan. The clinical director, as well as three non-licensed staff, provide substance abuse groups, all of which are qualified to provide substance abuse education. Three youth were interviewed in regard to specialized therapy; and all stated they are receiving specialized therapy. Three interviewed staff reported mental health and substance abuse groups are facilitated by clinical staff. According to the designated mental health clinician authority (DMHCA), intensive mental health services are provided at the program.

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

The program has a written policy and procedures to ensure mental health and substance abuse treatment is guided by an individualized treatment plan which addresses all of the youth's needs. Seven youth mental health records were reviewed for an initial mental health and substance abuse treatment plan. Each of the seven youth reviewed had initial treatment plans developed on the day of admission to the program. Each of the seven initial treatment plans contained the required elements of the Department's Initial Mental Health/Substance Abuse Treatment Plan. All seven initial treatment plans were developed by non-licensed staff and reviewed and signed off on by the clinical director. Each of the seven plans were also signed by the treatment team members, who participated in the development of the plans. Four of the seven records reflected the youth were in need psychiatric services to include medication and

frequency of monitoring by the psychiatrist. The initial treatment notes were completed on the progress note and signed by mental health/substance abuse clinical staff and youth.

Each of the seven reviewed youth records reflected each youth had an individualized treatment plan developed within thirty days of admission to the program. The individualized treatment plans were observed documented on a form containing all elements of the Individualized Mental Health/Substance Abuse Treatment Plan form. Each of the seven individualized treatment plans were signed by mental health or substance abuse staff completing the plan and were reviewed by the clinical director on the same day or within twenty-four hours. The signature dates of all seven plans matched the date the plan was developed. Three of the seven plans were missing the parent/guardian signature, in which case there was documentation the program mailed the plan to the parent/guardian; however, the plans were not returned to the program. Four of seven youth reviewed were applicable for psychiatric services, in which case, the individualized treatment plans reflected these services for all four youth. Individualized treatment plan reviews were observed to be documented on a form containing all elements of the Individualized Mental Health Treatment Plan Review form, every thirty days from the development of the plans. Documentation reflected all seven youth were participating in prescribed services as outlined in the individualized treatment plan. All seven records contained documentation of treatment team meetings were held on a monthly basis for each youth since admission to the program.

Three examples of treatment discharge summaries in three closed records were provided by the program for review. Each of the three discharge summaries reflected the youth was participating in mental health and substance abuse treatment while in the program. None of the three youth were applicable for suicide risk. The discharge summaries for all three youth reflected services needed daily for maintenance of the positive improvement in behavioral, emotional, and social skills made by the youth during treatment. Documentation reflected the discharge plans were discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference for all three youth reviewed. Documentation further reflected the discharge summary was provided to the youth, parent/guardian, and JPO for all three youth reviewed.

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 intensive mental health treatment services. Services include individual, group, or family therapy at least five days a week which are outlined in the youth's individual treatment plan. The program provides daily therapeutic activities (psychosocial skills training, psycho-education, supportive counseling) all provided by mental health clinical staff. Psychiatric services are provided weekly, on-site by the designated mental health clinician authority (DMHCA) who is a licensed psychiatrist. The program provides substance abuse services as they are licensed under Chapter 397, which expires July 6, 2019. The program has a licensed mental health counselor (LMHC) who serves as the clinical director and is on-site at least five days a week. The program has three non-licensed mental health staff who are on-site at least five days a week. The program is contracted with a licensed psychologist to provide services as needed. Therapists do not have caseloads which exceed sixteen youth. According to the program director, the program provides intensive mental health and substance abuse services.

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

The program provides psychiatric services which includes psychiatric evaluation, psychiatric consultation, and medical supportive counseling to youth with a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) and each youth receiving psychotropic medication. Psychiatric services are provided by a psychiatrist licensed under Chapter 458 meeting the requirements in Rule 63N-1, F.A.C. Seven youth mental health records were reviewed for psychiatric services. Four of the seven records reviewed were applicable for psychiatric services. Three of the seven youth reviewed were not applicable for psychotropic medication. Documentation reflected four of seven youth entered the program on psychotropic medication. Each of the four youth records contained documentation of a completed initial psychiatric interview. The initial psychiatric interview for each of the four applicable youth included: medical, mental health, and substance abuse history, mental status examination, DSM-IV-TR or DSM 5, treatment recommendations, prescribed medication, explanation of need for medication, and frequency of medication monitoring. All four of the initial diagnostic interviews were completed on the Department's form entitled Clinical Psychotropic Progress Note (CPPN). Page three of the CPPN included the youth's current prescribed medication, no changes were noted for any of the four youth. Each of the four applicable youth received their initial psychiatric interview within fourteen days of admission to the program. All four records contained documentation reflecting youth receiving psychotropic medication monitoring every thirty days by the psychiatrist. All four of the psychotropic medication reviews were documented on the CPPN. The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. Additionally, the psychiatrist visits the program every week on Sundays, for four hours, as evidenced by a review of sign-in sheets. The psychiatrist's recommendations for youth receiving psychiatric services are incorporated in the youth's individualized treatment plan. None of the four applicable youth reviewed were in foster care where the parent or guardian's rights have been terminated. The psychiatrist is responsible for the prescription and monitoring of psychotropic medications and actively participates, manages, and supervises psychotropic medication services in the program. The review and development of facility operating procedures (FOPs) or protocols related to psychiatric services are only performed by the psychiatrist and are reviewed annually. The program does not have standing orders or emergency treatment orders for psychotropic medications. The psychiatrist reported he is on-site once a week for four hours and conducts psychiatric evaluations and treatment.

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 suicide prevention plan which safely assesses and protects youth with elevated risks of suicide in the least restrictive means possible. The program's suicide plan includes the following: identification and assessment of youth at risk for suicide, staff training (six hours total), suicide precautions, levels of supervision, referrals, communication,

notification, documentation, immediate staff response, and a review process which includes suicide attempts and mortality reviews. The program's suicide response plan was observed to be reviewed annually. According to the program director, the program conducts mock suicide drills monthly, medical drills monthly, and all staff have been trained in cardiopulmonary resuscitation (CPR) and first aid.

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

The program's practice is the complete an Assessment of Suicide Risk (ASR) on every youth entering the program, regardless of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) results. None of the seven reviewed youth records reflected the youth were placed on precautionary observation as a result of the MAYSI-2 or ASR. The program was able to provide two examples of youth applicable for precautionary observation. Documentation reflected both youth were at risk for suicide based on staff observations. The precautionary observation start date matched the date in which staff observed the youth being at risk for suicide. The ASR for both youth was complete on the same day as the observations made by staff and date in which the youth was placed on observation. Both ASRs were completed on the Department's MHSA 004 form and both youth were placed on one-to-one supervision. Suicide logs for both youth were observed to be completed correctly with no lapses or missing observations. In both cases, precautionary observation was authorized by the clinical director and reviewed by the program director. Follow-up assessments were completed for both youth prior to the discontinuation of precautionary observation. The follow-up assessments included all elements required by the mental health and substance abuse manual. Discussion and review of both youth were observed documented prior to the reduction in level of supervision for both youth. The discontinuation of close supervision was observed documented in accordance with the program's suicide prevention plan. Notification of suicide risk to the parent/guardian and juvenile probation officer (JPO) was observed documented as required for both youth. One of the ASRs was completed by the clinical director who is a licensed mental health counselor (LMHC) and one was completed by a non-licensed clinical staff member. The non-licensed staff completing the ASR received the required twenty hours of suicide training. The ASR completed by the non-licensed staff member was reviewed by the clinical director the same day. A suicide alert was generated for both youth in the Department's Juvenile Justice Information System (JJIS), which were both subsequently closed by the program once the youth were no longer under observation. Precautionary observation logs allow youth to participate in select activities with other youth and did not limit a youth's activity to and individual cell. A review of the log books reflected documentation of both youth being placed on observation in which instructions related to the assessment findings and observation decisions were present. Neither of the youth reviewed were determined to be in immediate crisis.

The program has suicide response kits available in each living unit and each vehicle. The program has an established review process for a serious suicide attempt or serious self-inflicted injury, and a mortality review for a completed suicide which is included in the program's suicide response plan. The review process includes the following: circumstances surrounding the 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, and recommendations for changes in policy, training, physical plant, medical or mental health services and/or operational procedures.
Each of the three staff interviewed were familiar with and able to report what to do in the event a youth expresses suicidal thoughts.

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

The program has a written policy and procedures in place outlining the steps to take for youth who are placed on precautionary observation. None of the seven youth records reviewed were applicable for precautionary observation. The program was able to provide two additional applicable records for youth who had been placed on precautionary observation. The suicide precautionary observation logs (form MHSA 006) were observed to be completed for the duration of each youth's placement on observation. Documentation reflected the appropriate level of supervision and observations were documented in real time and did not exceed thirty-minute intervals. Both observation logs were reviewed and signed by the shift supervisor, as well as mental health staff. Warning signs were observed and documented on the suicide precaution observation log. Both youth placed on precautionary observation were available for interview. Both youth reported at no time while on observation, were they left alone by staff.

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

Seven pre-service and seven in-service training records were reviewed. Documentation reflected fourteen staff completed the required suicide prevention training (web-based and instructor-led). The program conducts mock suicide drills quarterly and on each shift. All staff with direct contact with youth on a day-to-day basis, participated in at least one quarterly mock suicide drill semi-annually. Drills were observed to include the use of life saving measures such as first aid and cardiopulmonary resuscitation (CPR), as well as use of the program's suicide response kit. Additionally, drills included methods for contacting other program staff by radio and the call for back-up support medical personnel and emergency services (9-1-1). Staff members who are not present during a quarterly mock drill have the opportunity to review the scenario.

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 program's crisis intervention plan includes the following: notification and alert system, means of referral (including youth self-referral), communication, supervision (one-to-one, constant, close and standard supervision), documentation, and review process.

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

The program has a written crisis intervention plan. None of the seven records reviewed were applicable for a crisis assessment and the program did not have any examples of a crisis assessment during the scope of the annual compliance review period. The program's crisis assessments include the following: reason for assessment, mental status examination and interview, determination of danger to self and others, initial clinical impressions, supervision recommendations, treatment recommendations, and notification for parent/guardian. In the event a crisis assessment is completed, either a licensed staff or non-licensed staff working under the supervision of a licensed staff member will be responsible for completing the assessment. According the written policy and procedures, the assessment will be conducted immediately or within twenty-four hours, based on the needs of the youth. Alert and notifications procedures were observed in the written policy and procedure.

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 plan. The plan includes the following: 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 Chapter 394, F.S. (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, F.S. (Marchman Act), documentation, training, and review process.

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

The program has not had any instances of Baker or Marchman Acts during this annual compliance review period; therefore, this indicator is rated as non-applicable.

Standard 4: Health Services

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

The designated health authority (DHA) is a licensed physician who holds an unrestricted license which meets all requirements for independent and unsupervised practice in the state of Florida. The DHA's license status is clear and active and will expire on January 31, 2020. The DHA's specialty training is in internal medicine. The DHA is on-site weekly, which was verified by the program's sign-in sheet. When the DHA is on vacation or scheduled absences, the program utilizes the psychiatrist. The DHA is available for communication with program staff regarding youth medical needs, and electronic availability twenty-four hours a day, seven days a week for acute medical concerns, emergency concerns, and coordination of off-site care.
When the DHA was asked to describe his role at the program, he indicated he reviews policy and procedures annually and as needed, performs comprehensive physical assessments, and conducts periodic evaluations. He said chronic clinic initial paperwork completed on admission. He reviews all labs and x-rays and signs off when on-site. He is on call twenty-four hours a day, seven days a week and available to nurses or staff onsite as needed.

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

The program has written policy and procedures for all health-related procedures and protocols utilized. The designated health authority (DHA) and program director (PD) signed and dated all respective treatment protocols and facility operating procedures (FOP). Documentation shows the DHA and nursing staff reviewed, signed, and dated a cover page for the FOPs, treatment protocols, and other procedures. A review of all FOPs and protocols is completed annually. All newly employed healthcare personnel receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, given by a registered nurse or clinic manager or licensed healthcare professional. Approval of treatment protocols or standing procedures are written and authorized only by the DHA. The program's psychiatrist or psychiatric advance registered nurse practitioner (ARNP) completes the review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management.

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

A review of seven individual healthcare records (IHCR) was completed. One youth had the original Authority for Evaluation and Treatment (AET), four youth had a copy of the AET, and two youth had a court order in their records. All five AETs are valid for as long as the youth is under any type of supervision, custody, or other form of legal control by the Department; or, for one year after it was signed by the parent/legal guardian, whichever comes first. The AET is valid until the youth's eighteenth birthday. All seven youth had parental notifications maintained in the IHCRs. Two of the seven youth were under the care of the Department of Children and

Families (DCF). Those youth's AETs were a court order signed by the judge, not by the DCF caseworker.

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 seven individual healthcare records (IHCR) was completed. Two youth were eighteen years old at the time of admission; therefore, did not require parental notifications. According to the clinical manager, the program has a packet they send to all parents/guardians of youth admitted to their program. The packet includes a notification of over-the-counter medications and vaccinations/immunizations not covered under the Authority for Evaluation and Treatment (AET). Parental notification of significant changes to existing medication, discontinuation of medication prescribed prior to entering custody of the Department, and changes in condition/medication for youth with chronic conditions. Any off-site emergency care, hospitalizations, surgeries/invasive procedures, non-routine dental procedures, and whenever and youth is taken off-site for medication treatment. All five applicable youth's records contained a copy of the packet sent to the parents/guardians.

Only two youth were eligible for documentation in the progress notes for parental notification for new medication and both were in compliance. In both records, written notification was sent regardless of telephone notification. A staff member witnessed all telephone call attempts and conversations for one youth and two out of three on the second youth. One of those youth's AETs was a court order signed by the judge, not by the DCF caseworker.

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.	

Only one of the seven youth met the criteria for this indicator, therefore, three additional files were reviewed. One youth did not have any changes to his psychotropic medication, therefore, parental notification was not required in all incidents. Three out of three youth had parental notification when a psychotropic medication was initially prescribed, discontinued, and/or significant dosage adjustment is made. All three had notification mailed along with the Clinical Psychotropic Progress Note (CPPN) for the initiation of psychotropic medication. All four youth had verbal consent obtained for the CPPN. For all four youth a staff member witnessed all telephone call attempts and conversations and documentation was on the CPPN. The three eligible youth had the CPPN sent to the parent/guardian for consent and confirmation, as well as signatures.

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).	

A review of seven individual healthcare records (IHCR) was completed and all seven had vaccinations verified within thirty days of admission. None of the records were applicable for

refusing consent for immunizations for religious or medical reasons. The nursing staff stated verification was completed through Florida Shots.

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.	

A review of seven individual healthcare records (IHCR) was completed and all seven had a Facility Entry Physical Health Screening (FEPHS) form completed on the date of admission by a registered nurse (RN) or a licensed practical nurse (LPN).

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 provided documentation of the internal medical alert system. A review of seven individual healthcare records (IHCR) was completed and none of the youth were identified with a chronic condition. Four of the youth were classified with a medical grade one and the other three were classified as a five. Six of the seven youth had allergies. One of the seven youth was identified with a visual impairment. The program's nursing staff verifies all alerts are up-to-date and the youth's internal alert system matches the alerts identified in the individual healthcare record.

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

A review of seven individual healthcare records (IHCR) was completed and all seven received a healthcare orientation upon admission to the program. This orientation included, access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process to include side effect monitoring, the right to refuse care and how it is documented, what to do in the case of sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers. The program has a physician who serves as the designated health authority, and a licensed psychiatrist who serves as the designated mental health clinical authority. Both are available by telephone twenty-four hours a day, seven days a week.

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.	

Only one youth was eligible out of the entire program's population for notification to the designated health authority upon admission. Upon admission, the nurse notified the designated health authority by telephone advising him of this youth's chronic condition. Three youth were interviewed and asked if they can ask for an HIV/Aids test and all three replied yes.

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.	

Three of the seven reviewed records were applicable for a healthcare admission rescreening. All three youth have had a change in physical custody since their arrival at the program. Upon return to the program, all three had a new Facility Entry Physical Health Screening (FEPHS) form completed by the nurse on duty. This form was filed in the youth's individual healthcare record (IHCR). Three youth were interviewed and asked how quickly they can see a nurse once they make a sick call request. One youth stated immediately, the second stated within one day, while the third said more than three days.

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.	

A review of seven individual healthcare records (IHCR) was completed. All seven youth had new health-related history (HRH) forms completed by a licensed nurse. Six out of seven of the HRH forms were completed on the date of admission. The seventh HRH form did not have a date for the nurse; however, the designated health authority (DHA) signed it five days after the youth's arrival. The DHA reviewed the HRH prior to or at the same time as the comprehensive physical assessment (CPA), as indicated by the checkbox on the CPA and his signature on the HRH. Three interviewed youth confirmed they can see a dentist if they have a tooth pain. All of the youth also confirmed they can see a doctor, if needed.

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.	

A review of seven individual healthcare records (IHCR) was completed and in all seven records, the program used the Department's comprehensive physical assessment (CPA) form. All seven youth were admitted to the program with a current CPA on file. A new CPA was also completed by the designated health authority (DHA), a medical doctor, upon admission. The CPA indicated the youth's medical grade and was completed in accordance with Department requirements. All sections of each CPA reviewed were marked with an "O." If the youth refused any part of the exam, "refused" was written and the youth signed the CPA the same day. All seven records had the Department's Problem List updated.

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

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

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

A review of seven individual healthcare records (IHCR) was completed. Seven out of seven records indicated the youth had one verified tuberculosis screening test (TST) documented in the individual healthcare records (IHCR) within the last year. All seven youth completed the Tier I tuberculosis screening within seventy-two hours of admission, as documented in the Facility Entry Physical Health Screening form. All seven youth were assessed prior to placement in general population and the results of the TST were documented on the comprehensive physical assessment and infectious and communicable diseases forms. This policy is in compliance with the Centers for Disease Control and Prevention and Occupational Safety and Health Standards.

Two of the three interviewed youth reported the nurse gives them their medication. Both youth reported they stand in line and wait for the nurse to call them up one-by-one. The third youth did not take medication.

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).	

A review of seven individual healthcare records (IHCR) was completed and seven were clinically screened and evaluated for sexually transmitted infections (STIs). Six of the seven youth were referred to the designated health authority (DHA) for further evaluation, which was documented on the STI form. Three of those six youth were ordered for testing by the DHA, which was documented in the progress notes. One youth's testing was rescheduled and is still waiting to get tested. The other two youth received their testing. The results are given directly to the youth from the Liberty County Health Department.

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 of the seven records reviewed were applicable for human immunodeficiency virus (HIV) testing. Reviewed documentation indicated all five youth were offered counseling, testing, and treatment for HIV. Two out of the five youth gave consent and were tested for HIV by a certified counselor. HIV testing is conducted at the local health department, which is where the pre/post-test counseling is also completed. This counseling was recorded on both youth's health education records. According to the clinical manager, the Health Department gives the sealed envelope directly to the youth. HIV results are not included in the program's internal alert system. The program follows the guidelines of Florida Statute 381.004, in which all HIV test results are filed in a confidential manner.

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.	

A review of seven individual healthcare records (IHCR) was completed. None of the youth presented similar sick call complaints three or more times within a two-week period, nor did the youth have any severe pain with which staff was unfamiliar. Five out of seven of youth had completed sick calls and all five had the sick call request form filed in the individual healthcare records (IHCR) in reverse chronological order. The sick call hours were posted on the sick call box, which is located outside of medical. Sick call takes place seven days a week at 3:00 p.m. and 5:00 p.m. by a registered nurse (RN) or a licensed practical nurse (LPN). All staff are trained to recognizing an emergency. If youth a is sick and staff does not believe it is an emergency, the youth will be seen the next day. The program does not have a computerized system for sick call.

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

A review of seven individual healthcare records (IHCR) was completed. Five out of seven of youth had completed sick calls. Four out of the five sick calls were completed by a registered nurse (RN), and one by a licensed practical nurse (LPN), which was reviewed by the RN the same day. All five youth's sick call forms were documented in accordance with the Department's Health Services Rule and on the sick call index. Four out of the five youth had the sick calls documented on the sick call referral log. Four youth signatures were documented at the time they were seen. Five out of five youth had the completed sick call request form filed with the progress note in the individual healthcare records (IHCR) in reverse chronological order. The medical department in this program allows youth privacy during sick call encounters. The youth have access to sick call forms, which are located in the dining hall, medical, and classrooms. Medical has an exam table and equipment used to perform sick call duties. The program's sick call process was observed during this annual compliance review. Staff escorted the youth to the medical department and remained within sight and sound of the youth. The youth provided verbal and written consent for the process to be viewed for the purpose of this annual compliance review. The RN identifies herself and the youth explains his reason for being there. No other youth are present during this examination. The youth is asked to sign to show they were seen. Three staff were asked who conducts sick call and all three replied the nurse. One staff added the doctor and two staff added the supervisor as well.

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's policy, procedure, and practice confirms the program does not use restricted housing; therefore, this indicator is 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.	

Two of the seven reviewed records were applicable for episodic/first aid care; therefore, an additional record was reviewed. All three records had documentation of the date/time of the episodic care, nature of complaint, findings of person rendering care, and treatment rendered. One of the three youth required a referral for off-site care. Two of the three youth needed education/instruction, while only one youth needed follow-up care. One of the three youth was placed on the internal medical alert system, which was verified. Two of the three youth were eighteen years old and the other youth did not require parental notification. All three records documented the name of the staff providing care to the youth. One of the three youth received a follow-up evaluation by a licensed healthcare staff. In all three records, the on-site licensed healthcare staff documented the subject, objective, assessment, and plan (SOAP) elements on the form. The medical department maintains an episodic log documenting all instance of first aid and/or emergency care.

The program has emergency medical and dental care, including emergency medical services available twenty-four hours a day. The automated external defibrillator (AED) is located outside the medical office. First aid kits are located on each dorm and in a cabinet in the administration building. The knife-for-life is located in each first aid kit for transport. A check of one random first aid kit verified it was fully stocked with approved contents. When the clinical manager was asked the process for monitoring the first aid kits, her system is to maintain the expiration dates on all the items in the first aid kit in a book and seal the kit. If the seal is broken, inventory will be completed immediately on the kit, if the seal is not, monthly inventory is completed and maintained by the nurse.

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

The program has a written policy and procedures addressing emergency care. The program has one operable automated external defibrillator (AED) with the instruction guide located outside the medical office. The licensed practical nurse (LPN) was observed conducting a self-test on the AED and checking the expiration dates during this annual compliance review. The registered nurse (RN) or LPN conduct monthly checks on the AED. The AED batteries expire in May 2022 and the AED pads expire in May 2021. The last date the AED batteries were changed was May 2018 and AED pads were May 2019.

A review of mock emergency drills was completed. These drills were conducted at least quarterly on each shift, to include cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), or first aid. The program has a list of emergency numbers, including Poison Control Information Center located on the bulletin board in each dorm, which is accessible to youth. All staff have been trained in the use of an epinephrine auto injector.
Three staff were interviewed and asked if they were personally allowed to call 9-1-1 if a youth has a medical emergency and all three stated yes. One added he would notify the supervisor first.

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

A review of seven individual healthcare records (IHCR) was completed and only four required off-site first aid or emergency care. One of the two youth was eighteen years old, so the youth did not require parental notification, one was under the Department of Children and Families' supervision and was not notified, the last two documented parental notification. All four youth had the summary of off-site care form utilized and filed in the IHCR, and three of the youth had discharge and other documents filed in the IHCR. The designated health authority (DHA) reviewed and signed all off-site care findings, instructions and information for four out of four of the youth.

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.	

None of the seven youth records reviewed were applicable for chronic illnesses; therefore, three additional records were reviewed. One of the three youth were identified on the Facility Entry Physical Health Screening (FEPHS) form as possessing a chronic condition, while the other two youth were identified after admission. All three youth were classified with the appropriate medical grade and received periodic evaluations no greater than three-month intervals. These evaluations were tracked, documented, and maintained in the individual healthcare records (IHCR). Periodic evaluations were conducted prior to renewal of a prescription medication which had expired. All three youth were placed on the chronic illness list and had a specialized treatment plan. The on-site evaluation was documented in the IHCR, as well as in the progress notes. The treatment orders were written so they were clearly distinguishable for clinical staff. None of the youth received an off-site evaluation or had a lapse in care or missed periodic evaluation. The Department's Problem List was updated, as required, for all three youth.

The program director revealed at intake during the orientation process he as well as the healthcare staff review important medical issues pertaining to youth at the program.

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

Three of the seven reviewed records were applicable for medication management. All three youth had been taking medication upon admission and the medications were verified prior to being accepted into the program and documented in the chronological progress notes. Once verification was completed, the designated health authority (DHA) was contacted to resume the medication for all three youth. All three youth were admitted when a nurse was on-duty. The program has a facility operating policy in place developed by the DHA for non-healthcare staff to follow if a nurse is not on-duty and when to notify the DHA if applicable.

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.	

Four of the seven reviewed records were applicable for medication management. One additional youth was prescribed medication immediately upon post-admission. All four youth's medications had a current and valid order. None of the youth had taken any over-the-counter (OTC) medications which were not listed on the authority of evaluation and treatment (AET).

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.	

All medications were observed to be stored in the secured medical department, which is not accessible to youth. All non-controlled medication was stored in a separate, secure, locked area, while narcotic and other controlled medications were stored behind two locks. This program does not have injectables but does store oral medications separately from topical medications. All syringes and sharps were found secured. The medication cart was clean and organized with items stocked separately from youth specific medications. The pharmacist comes and picks up all medication and destroys it.

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

The program provided documentation of all over-the-counter (OTC) medications being inventoried at least weekly, per Rule 63M-2.026(a). A perpetual inventory with running balances is maintained on all controlled medication with a shift-to-shift inventory requiring two staff signatures. Syringes and sharps are counted whenever used and weekly, using a perpetual inventory. The clinical manager stated if a discrepancy occurs, they will conduct a new count. The program has a protocol in place for disposal of narcotics and other controlled substances with the pharmacist. Inventories of three random youth medications, three random over-the-counter (OTC) medications, and three sharps were observed being completed by the licensed practical nurse. The nurse completed a medication count then verified the number matched the ending inventory numbers. All counts and inventories matched. Sharps are disposed of in a biohazard container. The program has a contract with a local laboratory for disposal of syringes.

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.	

All controlled medication is administered by either the registered nurse (RN) or licensed practical nurse (LPN) at this program. A count was observed being conducted by the LPN on three random controlled medications and found all medications matched the ending inventory numbers during this annual compliance review. The controlled medication was stored behind two locks in a cart in the secured medical department, where no youth have access.

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 of the seven reviewed youth records were applicable for a Medication Administration Record (MAR). The standard Department MAR form was used for all five youth. The MAR contained the youth's name, Department identification number, date of birth, allergies, precautions, medical grade, and a current picture of the youth in all five records. In four out of the five records, the youth were taking medication at admission and the initial MAR matched the medication list. The MARs indicated the youth received medication, as ordered, start/stop dates, and staff initialed each administered medication entry for all five youth. There were no lapses in medication for these five youth. All five records had documentation of weekly side effect monitoring on the MAR. If a youth refused medication, the refusal was clearly marked on the MAR, as well as on the refusal form. If there is a missed psychotropic medication dose, a call to the Central Communications Center would take place.

Three staff were interviewed and asked who provides medication to the youth. All three stated the nurse. One staff added the doctor and two staff added the supervisor as well.

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.	

A review of seven individual healthcare records (IHCR) was completed and none of the youth required parenteral medication. Medication pass was observed with the licensed practical nurse (LPN) in a clean and organized work space, and with the nurse in complete control of the medication containers and cart during this annual review compliance.

Upon observation, the youth was already in the medical building for sick call and had already identified himself, as well as the nurse, and what medication he would be taking and what for. Direct care staff was within sight and sound by the exit door. The youth was sitting on the exam table. The nurse then distributed the medication to the youth with a cup of water. The nurse observed the youth swallow the medication. The nurse then asked the youth to open his mouth to verify the youth swallowed the medication. No medication is pre-poured from the original packaging prior to administration. Three staff were interviewed and asked who provides medication to the youth. All three stated the nurse. One staff added the doctor and two staff added the supervisor as well.

4.32 Medication Management – Medication Provided by Non-Licensed Staff	Satisfactory Compliance
Trained, non-healthcare 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.	

None of the seven reviewed youth records indicated the youth were given medication by a non-licensed healthcare staff. One of the seven youth refused his medication, which was clearly marked and a refusal form was completed and filed in the IHCR. The clinical manager provided

a copy of the staff who had been trained in medication administration but stated it rarely occurs. This is only allowed to take place when medical staff are not on-site, and with self-administration of oral, topical, or inhaled prescribed medication. Observations of medication administration by a non-healthcare staff did not occur during this annual compliance review.
Three staff were interviewed and asked who provides medication to the youth. All three stated the nurse. One staff added the doctor and two staff added the supervisor as well.

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

Three of the seven reviewed youth records were applicable for psychotropic medications. The designated health authority (DHA) was notified for all three youth upon admission on a psychotropic medication. Two out of three youth had the psychotropic medication continued to be administered until an initial diagnostic psychiatric interview was conducted. All three youth had the initial diagnostic psychiatric interview conducted within fourteen days of admission. In all three records, the youth were referred to the psychiatrist within twenty-four hours of the mental health evaluation. The psychiatrist determined all three youth needed psychotropic medication and a psychiatric evaluation took place within fourteen days. An in-depth psychiatric evaluation was completed for all three youth within thirty days of admission for all three youth. The psychiatric evaluation was completed on a Twin Oaks form, which included page three of the Clinical Psychotropic Progress Note, (CPPN). The form included the diagnosis, target symptoms of each medication, and evaluation and description of effect of prescribed medication on target symptom. The CPPN also included prescribed psychotropic medications, side effects, the youth's adherence to the medication regimen, height, weight, blood pressure, laboratory findings, signature of the psychiatrist, date of signature, and documentation of monitoring Tardive Dyskinesia, if applicable, on a monthly basis for both records. Telephone contact with the parent/guardian to discuss medication only occurred for one out of the three youth. Those two youths were under the supervision of the Department of Children and Families. The program has no standing orders, emergency treatment orders, or PRN orders for psychotropic medication.

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

The program has a written policy and procedures for infection control which includes prevention, containment, treatment, and reporting requirements related to infectious diseases. The programs' infection control procedure includes common infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, as well as hepatitis A, B, and C, and HIV infectious diseases caused by blood-borne pathogens. The procedure also includes other outbreaks of epidemics caused by any other infectious agent, outbreak of lice and/or scabies, methicillin-resistant staphylococcus aureus, food-borne illnesses, bio-terrorist agents, chemical exposures, hepatitis B immunization for staff, and protective equipment available to staff. The program had no instances where the local county health department, should have been notified.

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

A review of seven individual healthcare records (IHCR) was completed and all seven indicated the youth received training in prevention of communicable disease and blood-borne pathogens. This documentation is on the health education record form in the IHCR. A review of seven pre-service and seven in-service staff training records indicated all staff completed the training based on the Centers for Disease Control and Prevention guidelines.

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

The program's exposure control plan is written in accordance with Occupational Safety Health Administration (OSHA) standards. The program's exposure control plan is located in the administrative building, which is available to all staff. The exposure plan is reviewed and signed annually by the administration or the program. Risk assessment and methods of compliance, as well as a comprehensive process is in place for needle stick post-exposure evaluation are included in the plan. The program director has established a separate file for youth and employees who have experienced a program/occupational exposure. This file is confidentially maintained for a ten-year period. The program had no instances where the local county health department, should have been notified. The program did not have any instances involving the quarantine or hospitalization of at least ten percent of the total population of youth or staff. The program director revealed the exposure control plan is located in medical and reviewed annually.

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

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

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

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

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

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

Standard 5: Safety and Security

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

During this annual compliance review, youth and staff were observed during different activities to include school, line movements in the garden, and in the dining facility. Per contract and facility operations procedures, the youth-to-staff ratio is eight-to-one during day during awake and asleep hours, and one-to-five during vocational activities and transports. Three staff were interviewed, and each knew the exact number of youth under their supervision during a particular time. No youth were observed to be roaming around the grounds freely. During the facility tour, the daily schedule was found to be posted in each living dormitory and the youth were engaged in the full schedule of activities.

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 outlining the behavior management system (BMS). A review of seven case management records revealed each youth's orientation included a review of the program's BMS. A review of seven staff training records revealed each staff was trained on the BMS. The BMS has not been changed since the last annual compliance review. The BMS contained all of the required information to include opportunities for positive reinforcement, opportunity for staff and youth to discuss impact of behavior on others, positive and negative consequences, and discussion of alternative behaviors. During the facility tour, there were postings of the BMS throughout the facility. Three youth and three staff were interviewed, and all stated they understood the BMS. The program director (PD) revealed the program has level/point system type of BMS with rewards and consequences. The PD revealed the program uses trend stat to monitor rewards to ensure rewards outnumber consequences, at a minimum of four to one. Two interviewed youth revealed staff are consist and fair with rewards and consequences. One youth stated it depends on who the youth is to determine the consistency of rewards and consequences. Three youth stated rewards consist of being able to go on field trips and play video games. Three staff interviews revealed rewards consist of off campus trip, point store, cookouts, and community involvement for youth. Three staff interviews revealed nothing other than the things earned by the youth can be taken away from the youth as a consequence.

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

A review of the program's behavior management system (BMS) revealed there is a protocol where staff are provided feedback regarding their implementation of the BMS. Three staff interviews revealed supervisors provide feedback to staff regarding the implementation of the BMS during briefings and other meetings. A review of the BMS revealed there is a process wherein staff and youth discuss sanctions imposed, consequences, and alternative acceptable behaviors. The BMS does not include increased length of stay, denial of a youth basic rights or services, promoting the use of group punishment, allowing youth to punish other youth, or include disciplinary confinement wherein a youth is isolated in a locked room as discipline for misbehavior. Two interviewed youth stated youth are not allowed to punish other youth. One youth stated staff allowed other youth to punish him. The youth did not want to make an abuse call. Program director was notified and revealed disciplinary actions were taken. He also receives a copy of all behavioral referrals for youth. All staff receive training on the BMS during their pre-service training and annual for in-service training. The program does not use room restrictions.

Three staff interviews reveal the youth have off-campus trips as rewards such as going out to eat, to the beach, bowling, skating, or to the recreation center.

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 in place concerning ten-minute checks. The program does not have any video or security cameras on-site to monitor youth. Ten minute checks are conducted and documented by staff manually at the program. The program has a ten-minute check form for youth during sleeping hours and anytime a youth is in their room for a period of time over ten minutes. A random selection of four dates were selected and the documentation shows ten-minute checks were completed for each youth and initial by staff. Three staff interviewed revealed room checks are conducted every ten minutes when a youth is placed in their room for sleeping or non-punishment reasons.

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 in place concerning youth census, counts, and tracking. A review of the logbook and shift reports from four different shifts (one from each dorm) found the program conducts counts at the beginning of each shift, after each outdoor activity, and during emergency situations. Three staff interviews revealed formal counts are conducted every hour. If there is a discrepancy, all movements are stopped, and another formal count is conducted. If youth are on the recreational field, they are moved to the dining hall when the second count is conducted.

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

The program's logbook was found to be bound with numbered pages. It was not found to be falling apart and there were no missing pages. A review of the logbook found each entry was made in ink with no erasures or white-out areas. All of the entries included the date and time of event, name of staff and youth involved, a brief description of the event and the name and signature of the staff making the entry. A review of the logbook found internal incidents reported to the Florida Abuse Hotline and/or Central Communications Center (CCC) were documented. The program summarizes in a shift report the events, incidents, and activities of the shift. During shift briefings the supervisors informs staff of the events and incidents of the previous shift. Staff on the incoming shift sign and date the shift report to document the review of the shift report.

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 on key control. The program has a system in place which includes 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, and reporting and replacement of damaged keys. The distribution and collection of keys for staff were not observed during the annual compliance review; however, when the annual compliance review team arrived at the program, an administrative staff took the visitors keys and locked them in a key box on the wall located in the administration building. Team members also signed-in and the time was documented. All keys were observed secured in the administration building behind a locked cabinet. Medical, youth and staff records, and youth personal property storage area keys are restricted only to personnel assigned who maintain those areas. Key inventory was reviewed, and it mated the actual key rings in use. Three staff were interviewed to check for personal keys. All three staff turned in their personal keys to the administration area, in receipt of their program keys. Three staff interviews reveal if a key is damaged or missing the supervisor is notified and internal incident report is conducted. When keys are found to be missing a thorough search is conducted and each youth is search. All damaged keys are reported to the assistant program director. Three staff were randomly selected and none of the staff had their personal keys in their possession.

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.*	

A review of the program's policy and procedures on contraband reveals it aligns with the Department's recommended guidelines for contraband. The policy includes all of the mandatory requirements. During orientation to the program, each youth is provided a youth handbook

which contains a list of items considered to be contraband. The handbook documented the consequences for violations related to possession of contraband or introduction of contraband into the program. To prevent the introduction of contraband, the program conducts physical searches, full body visual searches, facility perimeter checks, and physical plant searches. All visitors are searched with the electronic wand and all personal bags are searched before entering a secured area. The policy indicated searches shall be conducted on every youth moving within the facility and full body visual searches shall be conducted following outside activities and returning from off-site visits. The program director reported searches for contraband are regularly performed, as youth are frequently away from the facility completing work at the Department of Transportation (DOT) work sites. A review of the logbook found searches were documented. The program's policy and procedures address any staff who is found in possession of contraband will be subject to disciplinary action up to and including dismissal. The program director revealed when contraband is discovered it is turned over to the assistant director who disposes of it.

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 in place concerning searches and full body visual searches. According to the program's policy, searches are to be conducted before and after groups, before and after transports, before and after visitation, during admission and other movements throughout the program. Searches were observed during the annual compliance review. The searches were conducted by a staff the same gender of the youth. The staff was observed giving instructions to the youth and explaining the reason and extent of the search. Three interviewed youth stated searches and pat-downs occur when returning from off campus activities, after outdoor recreation, when items are missing, after visitation, and after work detail. Three staff interviewed reported youth are frisk searched when returning from off campus activities, after a home visit, after school, if something is believed to be missing, after visitation, and before/after movement.

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

The program has two vehicles designated to transport youth off campus. Both vehicles had the appropriate number of working seat belts, a suicide response kit, seatbelt cutter, and window punch. The fire extinguishers had a current inspection and were fully charged. The program has an approved first aid kit available for each vehicle. There was documentation the safety checks of the vehicles were conducted prior to each transport. The documentation also

supported a yearly maintenance inspection by a certified mechanic. Transportation staff were interviewed and understood the consistency of seatbelt usage.

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 related to the transportation of youth from the facility and it is in compliance with all requirements outlined by the Department relating to transportation of youth and driver eligibility. Interviews with three staff revealed cell phones and first aid kits are issued to staff for transports. The same three staff stated they are not allowed to use personal vehicles to transport youth. A transport was not observed during the annual compliance review. Upon request the program provided the review team with a list of approved drivers for transports and each staff had a current driver's license. Facility and personal vehicles were found to be locked when not in use.

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 developed a policy and procedures which outlined the audit/inspection process to include, at minimum, who is responsible for conducting the weekly security audits and safety inspections; the development and implementation of corrective actions warranted as a result of safety and security deficiencies found during any internal or external review, audit, or inspection; and, internal system to verify the deficiencies are corrected and existing systems are improved or new systems are instituted as needed to maintain compliance. A review of the policy of the policy revealed in met the requirements of Florida Administrative Code 63E-7.013 (5). Program director revealed the program has a clear process regarding the identification and tracking of deficiencies. If any deficiencies are noted a work order for repair is completed.

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 in place which addresses the issuance, inventory, and control of equipment and tools. A tour of the facility found tools securely stored when they were not in use. All of the tools were found to be marked for easy identification. The program conducts an inventory on all tools prior being used and following work activities. The program also conducts a monthly inventory of tools which do not have sharp-edges or points. There were no tools at the program not listed on the inventory. A review of seven in-service training records revealed each staff received training in tool management.

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 addressing youth handling tools and the supervision by staff. A tour of the vocational classroom revealed the program was in the correct staff-to-youth ration of one-to-five. Interview with the vocational teacher revealed youth are search after each work period. Risk assessments were completed on each youth who were participating in tool projects or activities. Three staff interviews revealed all youth use mops and brooms. Staff interviews also revealed youth who are taking vocational classes and work with Department of Transportation (DOT) use screwdrivers, hammers, drills, welding machines, shovels and rakes. Youth interview revealed the same results.

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 in place concerning outside contractors. A review of sign-in sheets revealed the program kept track of outside contractors and the tools used at the program. The form signed by outside contractors acknowledges policy requirements and documents the tools introduced and collected at the visit on the reverse side of the form. A review of the project invoices submitted to the program by the vendor matched the sign-in sheets of the outside contractors.

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 conducts practice drills on an annually and monthly basis. There was documentation of fire drills being conducted monthly. The documentation including the following information: type of drill, date and time of the drill, participants, brief scenario and findings/recommendations. The program director revealed fire drills are conducted monthly and other drills are conducted at least annually. Three youth were interviewed and two stated they were not instructed on what to do in case of a fire. Two youth stated they have not had a fire drill while at the program. One youth stated a fire drill was conducted in January 2019. Three interviewed staff revealed the have participated in the following drills within the last twelve months: weather, bomb threat, escape, fire, medical, and suicide drills.

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). A review of the plans revealed the plans provide for the basic care and custody of youth in the

event of an emergency or disaster and continuity of the care and custody of youth, while ensuring the safety of staff, youth, and public. The COOP included fire and fire prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The program provided documentation of the plan being submitted to the Department for approval on February 28,2019. An interview with the program director revealed the plans are available to all staff and located in the supervisor's office.

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 on the storage and inventory of flammable, poisonous, and toxic items and materials. The program only utilized two chemicals which are used for general cleaning. A tour of the facility found these chemicals were stored in a locked building with access limited to two staff with a small working inventory securely maintained in the administration building for daily issuance for cleaning. The inventory provided, matched quantities stored and the safety data sheets (SDS). The program does not store any flammable, poisonous, and toxic items and materials.

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 regarding youth handling and supervision of flammable, poisonous, and toxic items and materials. Youth are not allowed to possess chemical unless under direct supervision of staff. No youth were observed handling chemicals. During cleaning activities, staff spray the two cleaning chemicals which are maintained at the program and the youth wipes with a towel. Three interviewed youth revealed the youth used paint and paint stripper when painting the dorms at the facility. The youth revealed youth use bug spray in the garden as well.

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 on the disposal of flammable, toxic, caustic, and poisonous items. The operations supervisor is primarily responsible for the disposal of hazardous waste. The program does not store any flammable, toxic, caustic, or poisonous items, except for the disinfectant bathroom cleaner and a disinfectant cleaner. Staff disposes

the two cleaning materials and other liquid waste from work detail through the plumbing drains after use. The program director stated they have no flammable, toxic, caustic, and poisonous items stored. The program director revealed if these items were stored on-site, they would be disposed of at the at the local landfill. The program directed revealed the program has not had to dispose any flammable, toxic, caustic, or poisonous items since the last annual compliance review. A review of the disposal log revealed no disposals were conducted since the last annual compliance review.

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

The program has an activity schedule which documents a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth. A review of the logbook found the activities were documented according to the activity schedule. The program's contract requires a recreational therapist. The recreational therapist has a degree in recreational therapy or a bachelor's degree in a related field as outlined in the contract. Observations of the youth on the recreation field revealed youth are encouraged to explore interest and engage in constructive use of leisure time. The program has a formal process in place to promote constructive input by youth. Three youth interviews revealed youth are provided at least one hour of physical and leisure activities. These activities consist of basketball, football, working out, reading and watching television. Three staff interviews revealed youth participate in Boys and Girls club, basketball, football, volleyball, and kickball.

5.22 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Satisfactory Compliance

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

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

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

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

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

The program has a policy and procedures in place regarding participation in water-related activities. The program's water safety plan addresses safety, emergency procedures, and the rules to be followed during water-related activities. The program has two has two lifeguards who are certified consistent with American Red Cross. Each youth must take a swim test before participating in water-related programming to determine the risk level for each youth. A review of swim tests for thirty-nine youth found four of the youth were not successful during the test. Youth are given the opportunity to retake the swim test every thirty days. Two of the three youth interviewed stated they have taken a swim test and participated in water activities. The remaining youth stated he has not received his swim test as of the date of the annual compliance review.

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures addressing visitation, youth correspondence (mail), and use of telephone. During a tour, the visitation schedule was observed posted in areas accessible to youth and staff. The visitation policy is also addressed in the youth

handbook which is given to all you upon admission to the program. Visitation is scheduled every Sunday afternoon from 12:30 p.m. to 2:30 p.m.. Based on the youth's level on the behavior management system, youth can have visitation up to four times a month. Visitation is limited to parents/guardians, siblings, grandparents, juvenile probation officers, attorneys, and clergy. Visitations are pre-registered through contact with the youth's assigned case manager. Alternative visitation arrangements may be made, if determined necessary by the program. While at the program, youth are given the opportunity to communicate with family members during treatment team meetings, phone calls, and through letter writing. All incoming and outgoing mail are inspected by staff for contraband. Three youth interviews revealed they are given the opportunity to communicate with family members by mail, telephone or visitation.

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 participate in the use of a controlled observation room; therefore, this indicator is rated 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 participate in the use of a controlled observation room; therefore, this indicator is rated 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 participate in the use of a controlled observation room; therefore, this indicator is rated non-applicable.

Program Name: Juvenile Unit for Specialized Treatment
Provider Name: Twin Oaks Juvenile Development, Inc
Location: Liberty County / Circuit 2
Review Date(s): May 14-17,2019

MQI Program Code: 1086
Contract Number: R2105
Number of Beds: 32
Lead Reviewer Code: 141

Overall Rating Summary

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