STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Kissimmee Youth Academy: Borderline Developementally Disabled/Developementally Disbled
Youth Opportunity Investments LLC
(Contract Provider)
2330 New Beginnings Road
Kissimmee, Florida 34744

Review Date(s): September 15-18, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Gustavo Mazorra, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Teresa Andersen, Office of Accountability and Program Support, Deputy Regional Supervisor (Standard 5)
Norma Bolton, AMIkids Melbourne Center for Personal Growth, Director of Case Management (Standard 2)
Paul Czigan, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Cindy Jones, Office of Education, Deputy Education Director (Standard 2)
Tamara Mahl-Adkins, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Kamille Payne, Office of Accountability and Program Support, Regional Monitor (Standard 4)

Program Name: Kissimmee Youth Academy Borderline Developmentally Disabled/Developmentally Disabled
Provider Name: Youth Opportunity Investments LLC
Location: Orange County / Circuit 9
Review Date(s): September 15-18, 2020

MQI Program Code: 1426
Contract Number: 10287
Number of Beds: 32
Lead Reviewer Code: 185

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.04 Ten Minute Checks *	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/Consent	Satisfactory
4.05	Healthcare Admission & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	Designated Health Authority/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Illness/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exposure Control	Satisfactory
4.18	Prenatal Care/Education	Non-Applicable
4.19	Licensed Medical Staff*	Satisfactory

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Kissimmee Youth Academy: Borderline Developmentally Disabled/Developmentally Disabled (BDD/DD) is a thirty-two bed program, for fourteen to nineteen year old males, located in Kissimmee, Florida. The program is operated by Youth Opportunity Investments LLC, through a contract with the Department. The program provides borderline developmentally disabled/developmentally disabled services. The program fosters each youth by providing Skillstreaming the Adolescent, Trauma Focused-Cognitive Behavioral Therapy, Young Men's Work/Teen Relationships, and Impact of Crime. Additional treatment services provided includes individual, family, recreational, and group therapy. The program shares staff with another program co-located on the same campus. Program administration is comprised of a facility administrator, three assistant facility administrators, director of case management, designated mental health clinician authority, and health services administrator. Case management services are provided by the director of case management, five case managers, and two transition case managers. Mental health staff at the program includes the designated mental health clinician authority, who is a licensed mental health counselor (LMHC), an assistant clinical director (who is also an LMHC), six master's-level non-licensed therapists, and a contracted psychiatrist, psychologist, and certified behavioral analyst. Medical services are offered daily and are provided by two registered nurses and a contracted designated health authority who is a licensed medical doctor. Educational services are provided by the Osceola County School Board. The layout of the program includes one self-contained building with two wings separated by a common hallway which houses medical, staff offices, staff break room, and the administrative area. The BDD/DD program is located on one side of the building which includes three living units, of which one is currently occupied. The program has 108 security cameras providing coverage. All were operational at the time of the annual compliance review. At the time of the annual compliance review, the program had sixteen vacant positions including eleven safety and security specialists, two food service workers, one master control worker, and two therapists.

Strengths and Innovative Approaches

- The program has a well-established student council program which youth are encouraged to apply to represent their peers. Some of the creative and innovative groups developed by the student council include regularly scheduled breakfast or lunch with the assistant facility administrators and providing recommendations for family day themes, Distinguished Gentleman, and the Fab 5 young men's group, which is a group of five youth from the program, voted on by their peers in the program, who are eligible to engage in an incentive designed to target fellowship and help the youth develop as a young man. The Distinguished Gentleman program gives the youth the opportunity to earn the privilege to participate in the evenings of fellowship. The men of Alpha Phi Alpha, a fraternity whose main goal is to prepare young men for the greatest usefulness in the causes of humanity, freedom, and dignity of the individual, have provided volunteers to interact with youth on family day who may not get a visit.

- The program has an animal program. The program had one dog who sits with the youth during telephone calls and plays with youth during recreation. The program has goats and baby chickens. This animal program has grown to include more chickens and quail, with baby goats on the way. The goats assist in the lawn maintenance at the program and the administration has plans on starting a 4-H program, where youth learn to show the goats at the local fair.

Standard 1: Management Accountability

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

The program has a policy and procedures in place outlining the background screening process for newly hired staff. A review of the staff and contractor roster found the program hired ten new staff during the annual compliance review period. Each completed background screening in the Agency for Healthcare Administration's Clearinghouse system. Each screening was received prior to the hire date. A review of each reviewed personnel record found the program reviewed each staff's criminal history report, Staff Verification System (SVS) report, Florida Department of Law Enforcement's (FDLE) Automated Training Management System (ATMS), and Central Communications Center's (CCC) Person Involvement report prior to hire. Each staff record had documentation indicating the staff completed and passed a pre-employment assessment tool. The program uses the Diana Screen for the pre-assessment screening tool. None of the newly hired staff required an exemption prior to working with youth and none had a break in service indicated in the SVS. A review of the program's volunteer roster and sign-in logs verified the program did not have any volunteers during the annual compliance review period which required a background screening. The program did not employ interns during the annual compliance review period. The program utilizes teachers from the Osceola County School Board. The school board and the program submitted their Annual Affidavits of Compliance with Level 2 Screening Standards to the Department on January 9, 2020.

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

The program has a policy and procedures for the submission of a background rescreening to the Agency for Healthcare Administration's Clearinghouse system for staff after every five years of employment. A review of the staff and contractor roster found none of the staff were eligible for a five-year background rescreening during the annual compliance review period.
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1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance

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

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

The program has a policy and procedures in place establishing an abuse-free environment for youth and staff. All staff sign a Code of Conduct upon hire, which clearly outlines the expectation of ethical and professional behavior, including interacting with youth in a manner to promote safety. The policy clearly states staff will offer youth unhindered and immediate access to the Florida Abuse Hotline by immediately notifying a supervisor to facilitate the telephone call anytime a youth asks to use the hotline. During the program tour, postings for the Florida Abuse Hotline, as well as contact information for the Central Communications Center (CCC) for youth over the age of eighteen, were observed throughout the program. A copy of the program's provision for an abuse-free environment policy and procedures was obtained. The facility administrator was interviewed and verified the youth have unhindered access to the Florida Abuse Hotline and the staff are required to sign an Affidavit of Good Moral Character for the code of conduct upon hire.

A review of ten newly hired staff personnel records verified each staff signed an Affidavit of Good Moral Character upon hire clearly stating the expectations for all staff to create an abuse-free environment. The program had no allegations of staff abuse during the annual compliance review period. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment on February 21, 2020 and documentation found the program used the results of the assessment to incorporate trauma-responsive principles into the program planning process.

All five interviewed youth reported feeling safe in the program. Each of the youth reported they had never been hindered from calling the Florida Abuse Hotline and staff are respectful to them and other youth. Four of the youth stated they never hear staff use profanity, while one youth reported staff used profanity two or three times when directing youth line movement. All five youth indicated they have not had any improper social communication emails, telephone

numbers, or social media contact information with staff, such as Facebook, Instagram, Snap Chat, Tic Tok, etc.

All five interviewed staff reported staff have never hindered a youth from contacting the Florida Abuse Hotline. Each of the staff properly described this process and incited staff contact the supervisor and program administration and allow the youth to make the call. Each of the staff stated any staff can make the call. The five interviewed staff reported staff never use threats, intimidation, or profanity. A review of incident reports and youth records during the annual compliance review period, found no instances in which the Florida Abuse Hotline should have been called and was not. Observations, documentation, and youth and staff interviews verified the environment is free from physical, psychological, and emotional abuse.

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 did not have any incidents of physical, psychological, or emotional abuse during the annual compliance review period; therefore, this indicator is rated as non-applicable.

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

The program had five incidents reported to the Central Communications Center (CCC) during the previous six months. A review of documentation confirmed each incident was reported to the CCC within the required two-hour timeframe and all were found properly documented in the program's logbook with the CCC incident number. The program did not have an increase in CCC reports during the annual compliance review period compared to the previous annual compliance review period. There were no internal incident reports or grievances in which the CCC should have been contacted and was not. There were fifteen CCC incidents reported to the CCC during the past six months, which included three incidents related to the COVID-19 pandemic. An interview with the facility administrator revealed all staff have access to call the CCC, but standard practice is for staff to report the incident to a shift supervisor, who will then notify the assistant facility administrator and contact the CCC within two hours of discovery of the incident. If the assistant facility administrator is unavailable, the shift supervisor is authorized to make the call.

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

The program has a Protective Action Response (PAR) plan which was approved by the Department on February 9, 2019. The program had eighteen incidents in which PAR techniques were utilized during the annual compliance review period, which was an increase from the previous annual compliance review period. The facility administrator advised the increase was due to a youth who had nine PAR incidents in a two-month period, due to behavior issues. The program's PAR rate during the annual compliance review period was 2.44, which is above the statewide Residential PAR rate of 2.23.

Five PAR incidents were reviewed. A review of documentation confirmed each of the PAR reports were completed by the end of the staff members' workday, with statements by all staff involved. The reports were all reviewed within the appropriate timeframe by a supervisor, certified PAR instructor, and facility administrator within seventy-two hours and placed in a central file within forty-eight hours after the review. In all PAR incidents reviewed, each youth received a post-PAR interview within thirty minutes of the incident. None of the incidents required a post-PAR medical review, resulted in injury, or required a call to the Florida Abuse Hotline or Central Communications Center (CCC). None of the incidents involved the use of mechanical restraints. The program maintains monthly summaries of all PAR incidents which were provided to the Department each month within the required timeframe. The facility administrator reported the program conducts a mediation with each youth and staff prior to completion of the report and then each PAR report is discussed during the next morning management meeting.

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

The program has a pre-service training plan which was submitted to the Department on June 12, 2020. The program utilizes youth care worker I and youth care worker II positions as direct-care staff. Five staff training records were reviewed for pre-service training requirements. All five training records documented staff completed the required trainings in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, including standards of conduct, suicide prevention/intervention, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), human trafficking, and active shooter trainings within 180 days of hire and prior to contact with youth. Each staff completed a minimum of 120 hours of pre-service training. The program's contract outlines additional training required of the pre-service staff in key positions. One of the five staff was applicable for additional training and completed the additional trainings in areas of clinical documentation, male healthy relationships, and adolescent behavior. All completed training was documented in the Department's Learning Management System (SkillPro) within thirty days of training completion. Documentation was provided for all staff who provided training in CPR/first AED and PAR, verifying the staff were certified to facilitate the trainings.

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

The program has an in-service training plan which was submitted to the Department on June 12, 2020. The program utilizes youth care workers I and youth care worker II positions as direct-care staff. Five staff training records were reviewed for in-service training. Reviewed documentation confirmed each of the five staff completed in excess of forty-hours of training. Each of the five staff completed the required training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, suicide prevention, human trafficking, and active shooter trainings. Two staff training records were applicable for supervisory training. Both applicable records contained documentation indicated the staff completed eight hours of supervisory training in the areas of management, leadership, personal accountability, employee relations, and communication skills. All completed training was documented in the Department's Learning Management System (SkillPro) within thirty days of training completion. Documentation was provided for all staff who provided training in CPR, first aid, AED, and PAR. All trainers were certified to facilitate the trainings. The program maintains an annual in-service training calendar which is used to schedule and track annual training and is updated, as needed. The program provided copies of current CPR with AED certification for the licensed nursing staff.

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

The program has a policy and procedures outlining the grievance process. The policy includes training requirements of the grievance process. A review of staff training records determined staff received grievance training during pre-service and in-service training. The policy documents the grievance process in three phases, including informal, formal, and appeal phases. The informal phase is communication between the youth and involved staff. The formal phase includes a written grievance and response from a supervisory staff within two days. The appeal phase requires a response from the facility administrator (FA) within two days. Observations during the program tour verified the program made grievances forms available and a grievance box was located in the living unit. The grievance process was verified through an interview with the FA. The program maintains copies of all grievances for at least twelve months. The program had five grievances during the annual compliance review period, four of which were due to a broken air handling unit, which had already been reported and had a pending work order, and one because the educational classes were too challenging. All grievances reviewed were found to have been resolved within the appropriate timelines.

Five youth interviewed youth reported grievance forms are kept in the living unit and were aware of how to complete and submit them. The five youth were aware of each phase in the grievance

process having specific time frames for responses. Five interviewed staff reported the forms are kept throughout the program, youth can ask staff to assist in filling out the forms, if needed, and the grievances are required to be responded to within certain timeframes. All five staff were aware of the three phases in the grievance process.

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

The program's contract outlines four group interventions which must be delivered to the youth: Skillstreaming the Adolescent, Life Skills Training (LST), Trauma Focused-Cognitive Behavior Therapy (TF-CBT), and Impact of Crime. The LST and TF-CBT are evidence-based practices. Each of the ten staff members who facilitated groups during the annual compliance review period had the appropriate education, experience, and training in the curriculums delivered. The program contract requires Skillstreaming, LST, and TF-CBT curriculums to be delivered by master's-level clinicians to the program's borderline developmentally disabled/developmentally disabled population. A review of five youth treatment plans and all youth group notes confirmed each youth participated in the required groups. A review of sign-in sheets confirmed groups were held, as required. A review of the program's activity schedule documented youth are involved in structured and planned programming for over sixty percent of the day.

Five youth records were reviewed. Four of the youth records documented the youth were participating in three delinquency interventions and the remaining youth was participating in two delinquency interventions. Each youth was involved in at least one delinquency intervention which addressed one of the youth's priority needs identified on the Residential Assessment for Youth (RAY) and on each youth's performance plan. An interview with the facility administrator (FA) and designated mental health clinician authority confirmed the groups offered and which staff are responsible for delivering each group to the youth. In addition, the FA reported education and experience are factored into selecting who is assigned to facilitate each group. Prior to a youth's admission to the program, each youth record is reviewed and youth are matched to staff/counselors/case managers and intervention groups based on their history, as reported by youth and collateral information obtained from Department records and youth's service needs. All five interviewed youth reported they participate in multiple groups including Coping with Anger, Young Men's Work Group, Healthy Relationships, sexual abuse, and conflict resolution.

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

The program has a policy and procedures which requires all youth to receive life and social skills training while in the program. Skillstreaming the Adolescent groups aids in the youth's development of communication skills, interpersonal relationships and interactions, non-violent conflict resolution, anger management and critical thinking. In addition, the program provides Life Skills Training (LST), Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), and Male

Healthy Relationships. Reviewed documentation indicated each staff offering life skills groups had the appropriate education, experience, and training. A review of the program's activity schedule and group sign-in sheets confirmed groups were delivered, as required.

An interview with the designated mental health clinician authority (DMHCA) confirmed all youth receive life skills training and only staff qualified by the program's contract deliver life skills groups to the youth. Each of the five interviewed youth reported they are in several groups including Coping with Anger, Young Men's Work, Male Healthy Relationships, and Conflict Resolution. Each youth identified skills they were working on and indicated they practice skills by learning coping skills through role play in group.

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's contract requires restorative justice philosophy and restorative planning to be provided to the youth while at the program. The program's contract requires the youth to receive Impact of Crime (IOC) programming as part of the restorative justice planning. All five reviewed youth records indicated the youth participated in IOC. A review of sign-in sheets confirmed groups were delivered, as designed. The program provides opportunities for youth to engage in restorative justice activities, which may include completing court-ordered community services hours through cleaning and work projects around the program. Some of the current restorative justice activities all youth participate in include donating necessity items to the homeless, upkeep of animal shelters, and painting/cleaning of the facility. The main philosophy of restorative justice is to focus on repairing harm to people and relationships caused by crime. The restorative justice activities offered at the program assist youth in learning to accept responsibility, teaching youth about the impact of crime, exposing youth to the victims' perspective, and provides youth an opportunity to plan and participate in reparation activities. The facility administrator confirmed youth receive restorative justice education through IOC groups twice a week and participate in community service projects. All five interviewed youth reported participating in various groups. Due to the COVID-19 pandemic restrictions, the annual compliance review team was unable to observe the youth engaging in restorative justice activities.

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

The program's contract outlines the use of gender-specific programming for male youth with program components and treatment services which comprehensively address the special needs of adolescent males. Curriculums in Young Men's Work and Teen Relationships as the program's gender-specific services. A review of the program's activity schedule, group schedule, and group sign-in sheets verified the groups held, as required. The facility administrator and designated mental health clinician authority were interviewed and verified the youth are offered this combined curriculum to address gender-specific needs. All five interviewed youth reported they are in several groups including Young Men's Work Group.

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

The program has a policy and procedures outlining the process of entering and closing alerts in the Department's Juvenile Justice Information System (JJIS). The policy determines how alerts are identified, documented, and updated, as well as communicated to staff. Alerts are entered and updated in JJIS by the appropriate staff. Medical staff are responsible for medical alerts; the designated mental health clinician authority is responsible for mental health alerts; and the director of case management is responsible for classification and safety alerts. Four of the five reviewed youth records were applicable for alerts. Each of the applicable alerts were entered into JJIS and the internal alert system by the appropriate staff member and were updated, as required. All alerts were verified prior to entering into JJIS or the internal alert system. All alerts were documented in the program logbooks, as required. The annual compliance review team members verified youth alerts were maintained, as required, for case management, mental health, medical, and safety alerts.

The program utilizes a medical alert log, chronic conditions listing, and a master alert board, which is in the program administration conference room to ensure staff are aware of youth alerts. This board contains a photograph of each youth, the youth's Department identification number and age, and colored markers which designate each specific alert. Documentation verified the program's internal alert information is reviewed daily. The internal alert board is updated, as needed, by the appropriate program staff. All reviewed JJIS alerts were included in the program's internal alert system, as required.

The facility administrator reported all alerts are discussed during the morning management meeting, as well as daily shift briefings. Nursing staff are present at each morning meeting to discuss any important medical issues. Information is relayed during shift briefings, as needed. Medical staff are present during all staff meetings to provide important information to staff concerning any alerts. Five staff interviewed staff indicated they received updates on youth alerts from the alert board in the conference room, as well as shift briefings.

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 separate case management and healthcare records. The healthcare records were further divided into two separate records: mental health/substance abuse, and

medical for each youth. The file tab for the youth case management records documented the youth's name, Department identification number, date of birth, county of residence, and committing offense. Each youth records was marked "Confidential." The case management and mental health records were maintained in a locked record room, in the administration area, with signage designating the area as confidential. The medical records were kept in locked cabinets marked "Confidential" in the locked medical office.

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

The program has a policy and procedures in place to identify a formal method for youth to provide constructive input in the program. All youth have an opportunity to provide input through monthly surveys which are shared with staff during morning management meetings. The program has a student council which youth must apply to be a part of. The student council meets biweekly and the youth discuss different programmatic issues and any follow-up or changes as a result of their suggestions. The meetings are structured and provide opportunity for youth to ask questions, make recommendations, and have positive interaction with supervisory staff. The facility administrator confirmed the surveys and student council are a way for the youth to provide input. In addition, town halls are held on the housing wing monthly to solicit input from all youth with regards to the program. During this past year, youth have been chosen from housing wing to participate in the Fab Five which included dinners with staff. All five interviewed youth indicated the student council was a way youth could provide input, as well as speaking with staff directly.

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

The program has a policy and procedures in place outlining the purpose and establishment of a community advisory board. An advisory board meeting was observed during the annual compliance review. Due to the COVID-19 pandemic, the advisory board members from the community attended telephonically. Sign-in sheets and meeting minutes for the advisory board verified meetings were held quarterly during the annual compliance review period with all required members represented. The board is comprised and has active participation by local law enforcement representatives, multiple judges, community partners, members of the local business community, school board members, local faith community, parent/guardians of former youth and the lesbian/gay/bisexual/transsexual/questioning/intersex (LGBTQI) community.
A review of documentation found the program sent notification letters for upcoming meetings at least six weeks in advance of the meeting. The program had documentation indicating an e-mail calendar invite was sent to all participants to increase attendance. The program maintained accompanying responses for each meeting. The facility administrator explained the program recruits community resources through invitations, referrals, and staff recommendations. Local businesses have attended and participated in the meetings. The board has been involved with projects around the program including the addition of quail and additional goats for the agriculture program. During a board meeting observed by annual compliance review team members, a board member spoke and advised she had been a member of the community advisory board for over a year. She further said the board is in place to assist the program and youth in any way possible, and feels this board does an excellent job.

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

The program has a policy and procedures in place for program planning. This policy provides a provision for efforts to decrease turnover and increase staff morale. The program allows staff to provide feedback through surveys which are shared in the program's Key Performance Indicator (KPI) report. The program has a system of staff communication facilitated through daily shift briefings, management meetings, all team meetings, supervisor meetings, unit manager meetings, and staff morale meetings. A review of meeting minutes for the all-team meetings found the administration shares the results of the surveys and other data in the KPI reports, results for the Monitoring and Quality Improvement (MQI) report, and other data obtained with staff.

The program's morale committee meets monthly and discusses different activities and efforts to increase staff morale and decrease staff turnover. Due to the COVID-19 pandemic, some of the staff events were limited during the months of March – September 2020; however, the program did host staff appreciation lunches and breakfasts, as well as the annual Christmas party. These events included food and prizes such as gift cards and had large turn outs from staff.

The facility administrator (FA) reported the morale committee and monitoring of employee overtime are utilized to increase morale and decrease staff turnover. Due to the COVID-19 pandemic, unemployment, and other pandemic benefits, it has been hard to find good candidates for employment. The FA explained the morale committee meets monthly and plans activities for staff to participate. The program conducts hiring events twice weekly to hire new staff and reduce staff burnout.

The Comprehensive Accountability Report (CAR) report is used often in all staff meetings when discussing recidivism rates. The program uses the KPI report, Overtime Report, along with youth, parent/guardian, and staff surveys to assist in program planning.
Each of the five interviewed staff reported meetings are held daily and monthly and the information shared at these meetings is beneficial. All five staff indicated communication is good and staff are provided input into the program through an open-door policy with administration. A review of program vacancies found the program had sixteen vacancies during the annual compliance review period.

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 in place detailing the process for completing regular staff evaluations. An initial evaluation is conducted after the first ninety-days of employment and annually thereafter. A review of position descriptions for five pre-service and five in-service staff found each staff received a position description upon hire or promotion with clear performance expectations. A review was conducted of evaluations for five selected staff and found the evaluations were modeled after the position descriptions to evaluate staff on individual performances. The facility administrator verified staff performance evaluations are completed on an annual basis. In addition, all staff have monthly coaching meetings with a supervisor. This meeting helps staff know what needs to be improved on and what they are doing well. Four of the five staff reported evaluations are completed annually, while one said monthly. A review of

the program's vacancies found all key positions are filled, except for the recreation therapist. The recreation therapist position will be removed from the contract upon approval and execution of a contract amendment.

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

The program has a policy and procedures which outlines the recreation and leisure activities in youth programming. The activity schedule was reviewed and indicated the youth are provided with a variety of structured and unstructured recreation activities and leisure time throughout the week which gives youth exposure to various areas of interest. A recreation calendar is posted in the living unit for the youth to view. Recreation time is documented in the logbook through the youth movement. If the youth are unable to go outside for recreation, any environmental factors are noted in space provided in the logbook. The activities on the calendar are designed to promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation and physical fitness. Observations of recreation were not conducted.

Youth are engaged in physical education programming through the school. The recreation therapist position was vacant at the time of the annual compliance review; however, the position will be removed from the program upon approval of a contract amendment. A review of documentation indicated recreation services were provided to the youth despite the vacancy. Five youth were interviewed and each reported they receive a variety of recreation and leisure opportunities including basketball, baseball, football, soccer, bowling, boardgames, books, television, and cards. All five interviewed staff reported the following activities are provided for the youth: (Indoor) video games, weight room, board games, (Outdoor) soccer, football, basketball, for at least an hour each day.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures ensuring the timely notification of a youth's parent/guardian, committing court, and assigned juvenile probation officer (JPO) when the youth is admitted to the program. Five youth case management records were reviewed. All five records contained documentation in the youth case management records showing parents/guardians were notified by phone within twenty-four hours of the youth's admission. Four of the five youth case management records documented written notification to parent/guardian within forty-eight hours of admission. One written notification was three days late. All five reviewed youth records documented the notification of the youth's admission to the juvenile probation officer and to the court within five working days of admission, as required.

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

Five youth case management records were reviewed, and documentation verified orientation was conducted on the youth's day of admission. This orientation covered available services, daily schedule, youth expectations, behavioral management system, medical and mental health services, Florida Abuse Hotline, performance planning, contraband, dress code and hygiene, community access, grievance procedures, and emergency procedures. The program has a zero-tolerance policy regarding sexual misconduct. There were no youth admitted to the program during the annual compliance review. Five interviewed youth reported each were given an orientation within twenty-four hours of admission into the program.

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

The program has a written policy and procedures requiring the program to obtain written consent of any youth eighteen years or of age or older. None of the five reviewed records were applicable for youth eighteen years of age or older; therefore, three additional applicable youth records were reviewed. The three additional reviewed records contained the appropriate written consent forms, as required.

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

The program has a policy and procedures outlining the classification process. Five youth records were reviewed verifying the initial classification was conducted upon admission. The classification factors included the youth's physical characteristics, age, maturity level, special needs, history of violence, gang affiliation, criminal behavior, and vulnerability to victim and sexual aggression, and history of potential or verified human trafficking. A new Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) was completed and entered in the Department's Juvenile Justice Information System (JJIS) prior to assigning each youth to a room.

Youth records containing any special risk factors are entered into JJIS as an alert. A review of JJIS verified the appropriate alerts were entered. Reassessments were completed for four of the five youth records reviewed prior to increasing the youth's privileges, assignment to work projects or activities involving tools, as well as any off-campus activities. The fifth youth had not been in the program long enough for a reassessment to occur.

The facility administrator advised all youth to attend and participate in an Admission Classification meeting following intake prior to being assigned to a living/sleeping unit. The admission classification form is completed to identify any risk factors with regards to mental health, physical health, size, security criteria, medical criteria, and demonstrated behavior at intake.

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

The program has a policy and procedures in place for the identification and notification law enforcement of any youth involved or suspected as being involved in gangs (members, tattoos, other body markings). Two of the five case management records reviewed were applicable for gang affiliation; therefore, one additional applicable record was reviewed. The three applicable reviewed youth records contained appropriate notification to local law enforcement, the youth's assigned juvenile probation officer, school district, and home county law enforcement. Appropriate alerts for newly admitted youth with gang affiliation were properly placed in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures governing gang identification, prevention, and intervention. Two of the five case management records reviewed were applicable for gang affiliation; therefore, one additional applicable record was reviewed. The three applicable youth records indicated the youth participated in gang prevention and gang intervention groups. The performance plans for each youth included goals on gang intervention strategies to complete prior to the youth's release from the program. The program uses the Phoenix Resources for gang prevention/awareness instructional classes.

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

The program has a policy and procedures for the completion of an initial Residential Assessment for Youth (RAY) and reassessments for youth in the program. These assessments are required to be completed within thirty days of a youth's admission. All five reviewed records contained a RAY completed within thirty days of admission. A copy of the RAY was maintained in the Department's Juvenile Justice Information System (JJIS) as well. Four of the five youth were in the program over ninety days and required the RAY reassessments. The reassessments for each youth were completed within ninety days of the initial assessment, as required.

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

Five youth records were reviewed. Each of the records contained a Youth Needs Assessment Summary (YNAS). Each YNAS was completed within thirty days of the youth's admission and documented in the Department's Juvenile Justice Information System.

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

The program has a policy and procedures for the development of performance plans and goals. Five youth records were reviewed. All five records contained an Individualized Performance Plan. The initial performance plan was developed after the initial assessment and within thirty days of the youth's admission to the program. The performance plan development form was signed by the youth, treatment team leader, and all staff participating in the plan and goal development meeting. The performance plans documented the youth's responsibilities to accomplish goals, program staff responsibilities to enable youth to complete goals, and specific delinquency interventions.

All five youth records containing documentation verifying a copy of the plan was mailed to the youth's parent/guardian. The individual goals in each plan were based on each youth's needs and addressed the youth's top three criminogenic needs. Each plan included transition activities, detailing the responsibilities of the youth and staff, as well as target dates for goal completion for each activity. All five youth records contained documentation indicating a letter and the performance plan were mailed to the youth's committing court, juvenile probation officer, and the parent/guardian within ten working days of plan completion. Five youth were interviewed and all five indicated they participated in the development of the performance plan, were aware of their goals and received a copy of their performance plans.

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

Five youth case management records were reviewed for performance plan revisions. Four of the five records contained a performance plan revision which documented the youth's progress towards completing goals. The remaining youth record was not applicable, as the youth had not been in the program long enough to require a revision.

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.*	

Four of the five reviewed youth case management records were applicable for performance summaries and transmittals, as one youth had not been in the program long enough to require a performance summary. Each of the four applicable records had performance summaries completed at least every ninety days following the signing of the initial performance plan. The reviewed performance summaries documented the status of each performance goal, progress, grades, behavior, and indication of readiness to change.
The performance summaries were signed by the treatment team leader, staff member preparing the summary, facility administrator, and the youth. The chronological notes in each youth record indicated a copy of the performance summary was sent to the youth's committing court, juvenile probation officer (JPO), the youth, and the parent/guardian within ten business days.

Three closed youth records were reviewed for release summaries. All three closed records contained the original signed discharge summary. All of the discharge summaries were submitted to the youth's JPO, along with the Pre-Release Notification (PRN), at least forty-five days prior to the youth's release. The three reviewed records contained the notification to the parent/guardian once the court approved the PRN. An Exit Residential Assessment for Youth (RAY) was completed by the program after the PRN was approved and was documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures in place for the involvement of a youth's parent/guardian in case management services. Five youth records were reviewed. Each record contained chronological notes and copies of correspondence showing the program mailed pertinent documents to the parent/guardian upon the youth's admission which outlines the program and the importance of family involvement throughout the youth's stay at the program.

The facility administrator advised the case management process is explained to the parent/guardian at intake and a youth/parent handbook is mailed with the notification letter. Monthly treatment team letters are mailed to the parents/guardians with an invitation to the following month's treatment team meeting with the date/time of the scheduled meeting. During all informal and formal treatment team reviews, an attempt is made to contact the parent/guardian for participation. Parents/guardians are invited to attend Family Day on a quarterly basis; however, during the COVID-19 pandemic, Family Days were cancelled.

Three treatment team meetings were observed during the annual compliance review. During the treatment team meeting, the youth's parent/guardian and juvenile probation officer were contacted by phone for each meeting; however, two parents/guardians were not available to attend.

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

The program has a policy and procedures regarding members of treatment team. Observations of three treatment team meetings, and a review of five case management records, verified treatment team members include the treatment team leader, youth, treatment staff, nurse, living unit representative, transition coordinator, mental health, and administrative personnel. Education staff participated by telephone. The five youth records reviewed had documentation indicating treatment team meeting invites were sent to the parents/guardians and juvenile probation officers (JPO).

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

Five youth case management records were reviewed for the incorporation of other plans into the youth's performance plan. Each performance plan incorporated mental health, educational goals, and gang intervention, when applicable. One additional youth record was reviewed for Department of Children and Families (DCF) goals. The DCF youth record reviewed did not have any DCF goals on the performance plan; however, the plan was referenced in the performance plan.

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

The program has a written policy and procedures outlining formal and informal treatment team meetings. Five youth case management records were reviewed. Four of the five reviewed youth records were applicable for treatment team meetings. The remaining youth record was not applicable as the youth had not been in the program for thirty days. Each applicable youth record reviewed had a treatment plan in place to review treatment plan progress. The four applicable case management records had documentation indicating records indicated formal treatment team reviews were conducted at least every thirty days. All formal reviews were documented in each youth's case management record and included the youth's name, date of review, comments from treatment team members, a synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, and any behaviors resulting in physical interventions. Documentation was included in each youth record verifying the youth was provided an opportunity to demonstrate skills acquired in the program and review treatment progress. Residential Assessment for Youth

(RAY) Reassessment results were reviewed. A formal treatment team meeting was observed during the annual compliance review. The youth and all required staff were present. The youth's progress on Individualized Performance Plan goals were discussed, to include positive and negative behaviors and treatment progress. All members actively participated in the meeting and the youth was provided an opportunity to demonstrate skills acquired in the program. Each youth's treatment plan documented the anticipated release date. The Department's Juvenile Justice Information System (JJIS) reflected the anticipated release date was updated every ninety days and at the sixty-day transition conference. Five youth were interviewed and indicated they are given an opportunity during treatment team meetings to demonstrate any skills learned in the program.

Informal meetings were held with each youth bi-weekly in order to review each youth's performance and documentation also included the youth's name, date of review, comments from treatment team members, a synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, and any behaviors resulting in physical interventions as well as a review of the RAY Reassessment results.

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

The program has a policy and procedures to provide career education. The program provides Type 3 vocational competency development program. The Advanced Manufacturing course, provided by the Osceola County Schools educational staff, is age and skills appropriate, although many youth are not able to complete the certification requirements while committed to the program. The lead teacher advised a new career education program is being considered with the school district's administration to provide a more suitable course for youth at the program, allowing for certification completion. Career assessments are offered and completed, as well as pre-employment activities. Three closed youth case management records were reviewed. All three youth records included sample completed employment applications, a coversheet and resume, and each youth had a state-issued identification card. The three closed youth records contained information regarding each youth's local Career Source location and hours of operation, listed on the Calendar of Care.

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

The program has a policy and procedures to provide for educational access. The program integrates education into the daily schedule in such a way to ensure the integrity of the required minimum instruction time distributed over a twelve-month period. The district and daily school calendars were reviewed and were found to incorporate the required 250 days of instruction with less than ten days used for teacher planning. Youth are enrolled in academic courses through Osceola County Schools, currently using a block schedule format, and receive credits when courses are completed. An interview with the lead educator indicated the school schedule is adhered to daily. All five interviewed youth indicated there are no interruptions during the school day. The logbook review confirmed the program is following the school schedule.

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

The program has a written policy and procedures to provide for an educational transition plan. Three closed youth case management records were reviewed, and each youth's education transition plan addressed services and interventions based upon the youth's assessed educational needs, post-release education plans, as well as services to be provided during the program stay and to be implemented upon release. All required key personnel were included and the plan was developed with the youth, program, education, and aftercare staff involved. The plan placed specific monitoring responsibilities on individuals responsible for the reintegration and coordination of the provision of support services. All youth records included The Plan for Success and a Calendar of Care documenting appointments for post-release. All five interviewed youth felt like they were being well prepared for continuing education.

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

Three closed youth case management records were reviewed for transition planning, transition conferences, and Community Re-Entry Team (CRT) meetings. The three records contained documentation which verified a transition conference was held at least sixty days prior to the youth's targeted release date. A review of documentation confirmed the transition conferences were attended by the youth, treatment team leader, case manager, education, juvenile probation officer (JPO), and parent/guardian. The JPOs and parents/guardians were contacted by telephone. CRT meetings were conducted for all three youth, and attended by the youth, case manager, and JPO. A copy of the Microsoft Outlook calendar invite was maintained in one of the three records reviewed.

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. All of the records contained a state-issued identification card, copy of the transition plan, and calendar with all dates, times, and locations of upcoming community appointments. All three records had the youth's social security

card, birth certificate, school transcripts, resumes, and three completed sample employment applications. Each of the three records reviewed had documentation verifying the exit portfolio was discussed at the transition conference with each youth. The exit portfolios were given to the youth upon release from the program. Emails verified the case manager forwarded the exit portfolios to the youth's juvenile probation officer. The exit portfolio was verified at the exit conference for each youth. The three records reviewed contained a Receipt of Exit Portfolio form signed by the youth, which verified they received a copy of their exit portfolio, exit conference, and calendar with follow-up appointments 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 youth records were reviewed to ensure proper documentation of the exit conference. The three reviewed records contained documentation showing the exit conferences were held at least fourteen days prior to the youth's release date and the juvenile probation officer (JPO) was contacted prior to the exit conference. Each conference was attended by the youth, treatment team leader, education staff, JPO, and parent/guardian. The documentation showed the JPO and parent/guardian participated in the exit conference telephonically for each youth. A review of the Department's Juvenile Justice Information System (JJIS) verified the date of admission and date of termination matched with those in each youth record. Each exit conference was conducted separate from the Community Re-Entry Team meetings.

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

The program conducts a safety planning process for each youth. Five youth case management records were reviewed. All five records had a safety plan which included warning signs, crisis recognition, jointly developed coping strategies, intervention and debriefing preferences. The safety plans did not contain base line behaviors. All safety plans were completed within fourteen days of each youth's admission and were prepared by the youth, parent/guardian, clinical staff, and behavior specialist. Each plan incorporated recommendations from clinical assessments and included trauma responsive practices. The plan was updated every thirty days in four of the five records reviewed. The fifth youth had not been in the program thirty days; therefore, was not applicable. The safety plan is located in each of the sub-control rooms. All five interviewed staff were aware of the location of the safety pans. Staff stated they participated in the development of the safety plans. Each of the five interviewed youth advised they participated in the development of the safety plans.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a single licensed mental health clinician (LMHC) serving as the designated mental health clinician authority (DMHCA) in the position of the clinical director. The clinical director's license expires March 31, 2021. The position description for the clinical director reflects the clinical director is a full-time staff who is on-site at least forty hours a week and is responsible for the coordination and implementation of the mental health and substance abuse services in the program. The primary responsibilities include oversight, operation, and supervision of mental health and substance abuse assessment, treatment planning, and service delivery. The DMHCA is responsible for oversight of case management services within the program.

A follow-up interview with the DMHCA revealed she is on-site at least forty hours a week. She indicated the specialized services the program delivers are borderline developmental disability/developmental disability (BDD/DD) services including individual, group, and family therapy sessions. The clinical director personally provides screening, assessment, individual, group, and family therapy and crisis and emergency services when necessary; however, she does not carry a case load. The program subcontracts with a psychologist and a behavior analyst to provide services. When youth behavior indicates they are not responding to the normal behavior management system, the program makes a referral to either the psychologist or the behavior analyst as applicable for services. Behavior analyst services include not only coaching the youth, but also the staff on how to respond to the youth. Youth with trauma issues are generally referred to the psychologist.

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

The program has policy and procedures addressing licensed clinical staff. Each of the five mental health professionals providing services hold a clear/active license with the Department of Health, Bureau of Medical Quality Assurance. The program has two licensed clinicians, both of whom are licensed mental health counselors (LMHC). One of the LMHCs serves as the designated mental health clinician authority (DMHCA). The program has a corporate clinical director who is a LMHC. Each of the three LMHC's licenses expire March 31, 2021. The program contracts with a licensed psychologist whose license expires March 31, 2022. The

psychiatrist is a medical doctor whose license expires January 31, 2022. The contracted certified behavior analyst credentials with the Behavior Analyst Certification Board, Inc.® expires March 31, 2021.

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

The program has policy and procedures addressing non-licensed clinicians. The program has six non-licensed staff providing mental health and substance abuse services. Three of the staff have master's-level degrees in mental health counseling, two have master's-level degrees in social work, and one has a master's-level degree in the human services field. One of the mental health counselors is registered with the Department of Health, Bureau of Medical Quality Assurance as a registered mental health intern (RMHI). Each of the non-licensed staff graduated from an accredited university or college. The program is licensed under Department of Children and Families in accordance with Chapter 397, Florida Statutes to provide outpatient treatment substance abuse services with an expiration date of April 1, 2022.

Reviewed documentation indicated non-licensed staff completing Assessments of Suicide Risk (ASR) were provided twenty hours of training in administration of the instrument including five ASRs co-facilitated by a licensed mental health clinician. The program provided weekly clinical supervision of the non-licensed clinicians consistently during the annual compliance review period. Documentation indicated when a non-licensed clinician missed the weekly group supervision, the licensed clinician conducted an individual supervision session for the applicable clinician in the same week. A review of the schedule revealed mental health staff are on-site providing clinical services seven days a week. The clinicians were carrying case loads of no more than ten youth.

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

The program has a policy and procedures addressing mental health and substance abuse admission screening. A review of five youth records revealed each contained a Massachusetts Youth Screening Inventory, Second Edition (MAYSI-2) screening completed on the day of the youth's admission by staff trained in the administration of the instrument. Two of the screenings had an indication of suicide risk and each of the two youth were placed on precautionary observations and referred for an Assessment of Suicide Risk (ASR). The remaining three screenings revealed the youth required further assessment. Reviewed documentation revealed the program completed a documentation review of all available information during admission and documented on a single sheet endorsed by case management, mental health clinician, and the licensed clinician. Staff completed a referral for all five youth for further assessment for a comprehensive biopsychosocial assessment. The facility administrator or designee and clinical director were notified of the referral in each of the five records. Each of the five youth received

and ASR regardless of the results of the MAYSI-2 as part of the standard screening policy and practice.

An interview with the facility administrator regarding the screening process indicated the program has a contract with a board-certified behavior analyst to provide additional services, if required by the screening results. An interview with the clinical director revealed the program has a screening process which requires each youth, upon admission, to receive a brief behavioral mental status exam by a licensed clinician, records review, MAYSI-2 screening, ASR, and referral for further assessment.

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 policy and procedures addressing mental health and substance abuse comprehensive evaluations. The assessment instruments the program utilizes include the Massachusetts Youth Screening Inventory, Second Edition (MAYSI-2), Substance Abuse Subtle Screening Inventory (SASSI-2), Strengths Needs Abilities Preferences (SNAP), Beck Depression Inventory-II (BDI-2), and Confidence Exam.

Four of the five reviewed records contained a new comprehensive biopsychological assessment completed by a non-licensed clinician within thirty days of admission and referral. The remaining youth record did not contain an assessment; however, the youth has not been in the program for thirty days. Each of the assessments were completed by a non-licensed clinician and reviewed by the licensed clinician within the required time frame. Each of the assessments were signed by all required parties.

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 policy and procedures addressing mental health and substance abuse treatment. Each of the five youth records contained a properly executed Authorization for Evaluation and Treatment (AET), signed Youth Consent for Substance Abuse Treatment form, and a Youth Consent for Release of Substance Abuse Treatment Records form. Each youth record contained a treatment team assignment sheet which included the assigned mental health clinician and all other required team members/disciplines. Three of the youth treatment team assignment sheets were updated at least once since admission, indicating a change in staff assignment to the youth.

Three of the five reviewed youth records were applicable for substance abuse treatment services. Each of the three applicable youth were receiving substance abuse services by a licensed provider or a non-licensed provider supervised by a licensed provider under Chapter

397 license. Services were provided in accordance with each youth's individualized substance abuse treatment plan. A review of five youth records revealed each provided clinical service was documented on a mental health and substance abuse treatment note containing all required elements. Group therapy was limited to ten youth. Individual, group, and family therapy was provided by a licensed clinician or a non-licensed clinician working under a licensed clinician. The program was not providing substance abuse groups; however, substance abuse issues were addressed during individual therapy and skill groups, which addressed substance abuse-related skill building. Individualized treatment plans included the frequency of prescribed services for each youth including individual, group, and family therapy. A review of case notes revealed each youth consistently received services according to the frequency prescribed the individualized treatment plan.

Each of the five interviewed youth reported they received both family and individual counseling services. The frequency described by youth included family counseling once a month and individual counseling once a week. Four of the five interviewed staff indicated they have no responsibility to conduct mental health or substance abuse groups. The remaining staff, who was a mental health clinician, indicated she conducts mental health and substance groups and related skill groups daily. She revealed Monday is Young Men's Work, Tuesday is skills group, Wednesday is cognitive behavior therapy, Thursday is Seven Challenges, Friday is teen relationships, Saturday is skills group, and Sunday is Seven Challenges. The mental health clinician also facilitates groups at the program co-located on the same campus.

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 policy and procedures addressing treatment and discharge planning. The process includes each youth to receive an initial treatment plan on the day of admission, an individualized treatment plan within thirty days of admission, and discharge planning included in each treatment plan. Each youth receives a mental health and substance abuse discharge summary prepared prior to the exit staffing and delivered to the youth, parent/guardian, and juvenile probation officer at discharge.

A review of five youth records revealed each record contained an initial treatment plan completed on the day of admission. Three of the five youth were admitted with prescribed psychotropic medications and the initial treatment plan included goals for the psychiatrist to interview the youth and receive medication monitoring every thirty days. Each of the three initial treatment plans included the name of the medication and dosage. All five initial treatment plans were signed by the non-licensed clinician and all required parties on the day of admission including the licensed mental health clinician authority (DMHCA).
Three of the five reviewed records contained an individualized mental health and substance abuse treatment plan completed within thirty days of admission which included all required

elements. Each individualized treatment plan was signed by all required parties within thirty days of admission and by the DMHCA within ten days of completion. Two of the five reviewed records did not contain an individualized treatment plan as neither youth had been admitted thirty days prior to the review. The program still had time to complete each individualized treatment plan before the thirty days was up.

The program contracts with a certified behavior analyst and psychologist, who provided services following a referral from the mental health team. Services were rendered in accordance with each youth's treatment plan and documented in treatment notes supported by attendance at treatment team meetings; however, these services were inconsistently incorporated into the individualized treatment plan or monthly treatment plan updates. The program conceded although the youth was receiving behavior analyst and psychologist services, the plans were not enveloped into the mental health and treatment planning process; however, none of the reviewed youth records were applicable to receipt of behavior analyst or psychologist services.

One youth's individualized treatment plan indicated the frequency of individual therapy sessions was three a month and frequency of groups was one trauma-focused cognitive behavioral therapy a week; however, a review of progress notes indicated the youth was receiving weekly (four times a month) individual therapy sessions and daily (seven a week) group therapy sessions, two of which were one trauma-focused cognitive behavioral therapy. The program recognized the error of the frequency of sessions and revised his treatment plan June 11, 2020. All individualized mental health and substance abuse treatment plans since June 11, 2020 have included the more specific frequency of treatment sessions.

None of the selected youth records were applicable for discharge planning; therefore, three closed youth records were reviewed. Each of the three closed records contained a mental health and substance abuse (MHSA) treatment discharge summary completed on the required form. None of the youth were applicable for notification of suicide risk at discharge. Each MHSA discharge summary considered the services needed for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by the youth during treatment. There was documentation indicating the discharge plan was discussed with the parent/guardian and juvenile probation officer (JPO) during the exit staffing. There was documentation in each youth record reflecting a copy of the MHSA discharge summary was provided at discharge to both the youth and parent/guardian and emailed to the JPO.

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

The program provides specialized borderline developmental disability (BDD) and developmental disability (DD) treatment services. Each youth received an individualized treatment plan based on a developmental evaluation as part of the developmental disability treatment planning. Each youth received daily developmental and psychosocial treatment and intervention activities. Youth with co-occurring disorders receive mental health and substance abuse services. A psychiatrist is on-site weekly and provides initial psychiatric evaluation to each youth upon admission. The psychiatrist provides updated psychiatric evaluations following referrals, medication monitoring every thirty days for applicable youth, and attends treatment team meetings, providing psychiatric updates as needed. Mental health clinical staff are on-site providing services seven days a week. The program contracts with a certified behavior analyst

to provide services weekly. Counselor-to-youth ratio assignments do not exceed one-to-ten. An interview with administration revealed the program's specialized services included BDD and DD.

3.09 Psychiatric Services (Critical)	Satisfactory Compliance
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C. ****Tele-psychiatry is not currently approved for use in Residential Programs****	

The program has policies and procedures addressing provision of psychiatric services. The program has a contract with a physician who has completed a psychiatric residency and is board eligible for certification. The psychiatrist holds a clear and active license with the Department of Health, Bureau of Medical Quality Assurance with an expiration date of January 31, 2022. The psychiatrist is on-site weekly and available twenty-four hours a day, seven days a week for consultation. A review of the sign-in log revealed the psychiatrist weekly services were consistently less than nine days apart.

A review of five youth records revealed each youth received an initial psychiatric evaluation within seven days of admission. The evaluations were documented on the Department's Clinical Psychotropic Progress Note (CPPN) including page three. Three of the youth were admitted on prescribed medication and continued on the same regimen. One of the youth's medication was discontinued. Two youth were recently admitted to the program and had only received an initial psychiatric evaluation. One of the two youth was on psychotropic medication and there was not enough time in the program to require the thirty-day medication monitoring. Two of the other three youth were on medication upon admission and the psychiatrist continued the medication. Each of the youth on psychotropic medication had an evaluation which included a DSM-IV-TR or DSM 5 diagnosis, treatment recommendation, prescribed medication, explanation of the need for medication including target symptoms, initial treatment goals, potential side effects, risk/benefits of taking the medication, and frequency of medication management. Each time the psychiatrist performed medication management or an update to the initial psychiatric evaluation, the CPPN including page three was utilized. The three youth who had been taking psychotropic medication received psychiatric medication management every thirty days, which was documented on the CPPN form and included page three. The monthly medication management documentation consistently included identifying data, diagnosis, target symptoms of each medication, evaluation and description of effect of prescribed medication on the target symptoms, the name, dosage, and quantity of medication, normal dosage range, ordered dosage range, frequency, and route of administration, and if applicable, reasons for changes in medication and/or dosage, side effects, and youth's adherence to the medication regime. In two applicable records, the required contacts with the parents/guardians were documented on page three of the CPPN including the signature of the psychiatrist, date of signature, and witness. The psychiatrist consistently documented monitoring for Tardive Dyskinesia on a monthly basis.

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 in place which received a revision and annual review January 10, 2020 and an endorsement by the new clinical director August 3, 2020. During the update, most of the language updates from the Department were incorporated with the following exception: the definition of one-to-one supervision is missing one phrase requiring supervision “including when the youth uses the shower or toilet;” however, the plan included procedures for identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process.

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

A review of five youth records revealed each youth received an initial Assessment of Suicide Risk (ASR) at admission. One of the five youth records was applicable for suicide prevention services including two occasions in which the youth was placed on constant supervision and referred for an Assessment of Suicide Risk (ASR). One of the occasions was upon admission. In each record, staff alerted mental health and the supervisor, and started a precautionary observation log. The program provided an additional applicable youth record for a youth who had been discharged but had been placed on precautionary observation prior to discharge.

In each of the three records, precautionary observation was authorized, a suicide alert was entered into the Department’s Juvenile Justice Information System (JJIS), and mental health followed-up with an ASR within the required time frame. Each of the ASRs was completed by a licensed mental health clinician. One youth was stepped down to standard supervision, one youth was continued on constant supervision, and one youth was continued on one-to-one supervision. The youth on constant supervision was maintained on precautionary observation with a follow-up Assessment of Suicide Risk (FASR) conducted every twenty-four hours until stepped down to close supervision and then to standard supervision, in accordance with the program procedures. The remaining youth was continued on one-to-one supervision receiving a daily FASR until he was arrested and removed from the campus. Each of the ASRs and FASRs documented notification of the parent/guardian and the juvenile probation officer, as well as consultation with the mental health authority and the facility administrator or designee. Each instance of a youth placed on and taken off precautionary observation was documented in the program logbook citing the mental health authority decision. Each occasion of precautionary observation documentation included safe housing areas, youth were allowed to participate in

select activities, and youth were not restricted to an individual cell or sleeping room. Interviews with administration revealed the program does not utilize secure observation. A review of five youth records revealed the program had no instances of the use of secure observation.

Training documentation for each non-licensed clinician who completed ASRs was reviewed. The training documented twenty hours of instruction in suicide risk and included each non-licensed clinician conducted five ASRs which were co-facilitated with a licensed clinician.

The program has a suicide response kit in each of the two sub-control rooms. Observations of each kit revealed each kit contained all three required tools which were serviceable. All five interviewed staff indicated the suicide response tool was maintained in the sub-control. All five staff indicated they would notify mental health, search the youth and room for sharp objects, maintain constant sight and sound supervision, and document the supervision if a youth expressed self-injurious thoughts. One of the five staff indicated they would place the youth in a locked room; however, program indicated secure observation was not utilized. This information was shared with the program. The staff was recently hired by the program and was not familiar with the procedures. A review of five youth records did not reveal any youth at risk of self-inflicted behaviors being locked in a room validating there was no practice of secure observation. One youth who had been placed on suicide precautions was still in the program. The youth indicated staff never left him alone but was with him at all times while on suicide precautions.

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.	

Three instances of a youth placed on precautions were reviewed for suicide precautionary logs. Each of the logs were maintained for the duration of the youth on suicide precautions. The appropriate level of supervision and observations of the youth’s behavior were documented in real time and did not exceed thirty-minute intervals. In one applicable instance, warning signs were observed, properly documented, and mental health was notified. Each of the suicide precaution logs was reviewed and signed by each shift supervisor and mental health clinical staff. Each of the suicide observation logs documented the safe housing requirements.

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

The program has policy and procedures addressing suicide prevention training. Five in-service training records were reviewed for suicide prevention training. Each of the five staff received six hours of suicide prevention training including four hours of instructor-led and two hours on the Department’s Learning and Management System (SkillPro). The program documented suicide drills were completed no less than quarterly on each shift for all staff who come into contact with youth. A review of the suicide drills revealed each of the twenty-nine reviewed staff participated in at least one drill in each of the previous four quarters. Each of the quarterly drills utilized the suicide response kit and brought the automated external defibrillator (AED) as an available tool. Each drill included the use of life saving skills such as cardiopulmonary resuscitation (CPR) and

first aid practices. Suicide drills were discussed at all-staff meetings for staff who were unable to participate in the actual drill.

An interview with administration revealed the program provides training or drills for staff, including emergency response to suicide attempts or self-inflicted injury, quarterly on all shifts. Five staff were interviewed regarding the frequency of mock suicide drills. One staff said they participate in mock suicide drills once a week, one said twice a week, one said once a month, one said twice a month and one said two to three times a month.

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 mental health crisis intervention plan separate from the emergency mental health and substance abuse services plan. The plan included notification, an alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The plan included the use of the Department's Crisis Assessment form. The crisis intervention plan received a revision and annual review January 10, 2020 and an endorsement by the new clinical director August 3, 2020.

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 policy and procedures addressing crisis assessments. The program had one incident which required a crisis assessment. The youth received a Crisis Assessment conducted by the licensed clinician within the required time frame utilizing the Department suggested form which included all required elements. The recommendations include the youth was to remain on standard supervision. The Crisis Assessment documented consultation with the facility administrator or designee and included signatures and notification of the applicable parties. There was no requirement for follow-up assessment or mental health alert.

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 services plan separate from the crisis intervention plan. The plan included immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services including Baker Act and Marchman Act, documentation, training (including mock drills), and review. The emergency services plan received a revision and annual review January 10, 2020 and an endorsement by the new clinical director August 3, 2020.

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

The program had three instances in which a Baker Act procedure was utilized during the annual compliance review period. There were no occasions during the annual compliance review period requiring the use of the Marchman Act. All three instances concerned the same youth in three different months of his commitment. In each of the three instances, staff immediately referred the youth to mental health and maintained one-to-one supervision. A licensed clinician conducted the Assessment of Suicide Risk (ASR) which recommended Baker Act. Law enforcement transported the youth on two occasions and emergency medical services (EMS) transported the youth on the third occasion. In one of the law enforcement transportation occasions, the crisis unit was full upon arrival. Two program staff picked up the youth and transported the youth to another crisis unit with clinical director and facility administrator or designee's authorization. On the occasion of the youth's return to the program, the youth was placed on constant supervision and referred to mental health. The mental health clinician conducted an ASR within the required time frame and continued the youth on constant supervision. In two instances, the youth was maintained on constant supervision until stepped down to close and then to standard supervision according to program policy. On the third instance, the youth was arrested and removed from campus by law enforcement while still on one-to-one supervision.

Standard 4: Health Services

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

The program has a policy and procedures establishing the role and responsibilities of the designated health authority (DHA). The program has a contract in place with a medical doctor to serve as the DHA. The program's DHA has a clear and active license in the State of Florida with an expiration date January 31, 2022, and a specialty in internal medicine. The DHA has valid liability insurance with an expiration date of July 22, 2021. The program has a back-up DHA with a clear and active license in the State of Florida with an expiration date January 31, 2021, and valid liability insurance with an expiration date of July 1, 2021; however, the back-up DHA was not on-site during the annual compliance review period. A review of DHA sign-in logs confirmed the DHA was on-site weekly during the annual compliance review period and never more than seven days between visits. On two occasions, the DHA was on-site for less than the contracted time of two hours; however, documentation supported the DHA completed all clinical and administrative duties, as required, during the time on-site. An interview with the DHA revealed and documentation confirmed, the DHA's responsibilities include conducting comprehensive physical assessments (CPA), sick call, episodic care follow-up, off-site care follow-up, periodic evaluations, communication with staff on medical care, and the development and approval of healthcare-related policy and procedures. The DHA confirmed they are on-site weekly and on-call for consultation twenty-four hours a day, seven days a week.

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

The program has healthcare policy and procedures in place which establish the provision of medical care at the program. The policies were approved by the designated health authority (DHA), facility administrator (FA), and the regional nursing director. Policies regarding psychiatric services were approved by the psychiatrist. The policies received an annual review by the DHA, FA, and all nursing staff March 5 and 6, 2020. The program also has nursing protocols which outline approved treatment services rendered by healthcare and non-healthcare staff. These protocols were approved by the DHA and FA and were last reviewed by the DHA, FA, and nursing staff February 25, 2020. The program did not have any nursing staff hired during the annual compliance review period.

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.	

The program has a policy and procedures in place necessitating an Authority for Evaluation and Treatment (AET) or court order to authorize the provision of medical care for youth. Five youth individual healthcare records (IHCR) were reviewed and found each contained a valid AET stamped as a "copy" on the form. The program did not have any youth during the annual compliance review period who were in the custody of the Department of Children and Families. An interview with the nurse revealed if a youth does not come into the program with a valid AET,

the nursing staff will call the parent/guardian to notify them of the need to complete the form and then send the form for parent/guardian consent.

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

The program has a policy and procedures for obtaining consent for treatment and medications, as well as notifying parent/guardians of medical care. Five youth individual healthcare records (IHCR) were reviewed and each had the required notifications sent to the parent/guardians utilizing the Department form. Three youth were applicable for verbal consent to the parent/guardian prior to the administration of treatment or medications. Each of the three applicable IHCRs documented parent/guardian consent, as required, and witnessed by a second staff member. One of the youth received off-site emergency care and documentation supported the program contacted the parent/guardian, provided an update on the youth's care, and sent a written notification, as required. Four youth IHCRs were applicable for psychotropic medications and each youth's IHCR had documentation all consents were obtained and noted in the IHCR prior to administration of the medication.

Each of the four IHCRs contained a Clinical Psychotropic Progress Note (CPPN) which documented the consent to treatment prior to the start of any new or significant changes in psychotropic medications. Each of the five youth IHCRs contained vaccination records which had a review documented by the nursing staff within one day of the youth's admission to the program. None of the youth were applicable for new immunizations or parent/guardian refusal of consent to immunizations in the program. The program did not have any youth in the custody of the Department of Children and Families (DCF) during the annual compliance review period. The health services administrator (HSA) was interviewed and reported vaccinations are verified with the Florida Health Certification Immunization form by a registered nurse upon the youth's admission.

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

Five youth individual healthcare records (IHCR) were reviewed for a Facility Entry Physical Health Screening Form (FEPHS) and each IHCR contained a FEPHS completed upon the day of admission by a registered nurse. There were no youth applicable for a change in custody requiring a FEPHS re-screening during the annual compliance review period.

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

Five youth individual healthcare records (IHCR) were reviewed and documentation was found each youth received a general orientation to healthcare services upon admission. Each youth signed a form at admission documenting all education given, which included all required healthcare orientation topics. In addition, all education was documented on the youth's Health Education form.

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

Five youth individual healthcare records (IHCR) were reviewed for admission notification to the designated health authority (DHA). Two of the five youth were applicable for chronic health conditions identified upon admission; however, documentation verified the DHA was contacted by telephone anytime a youth was admitted to the program and informed of any medical information, including chronic conditions. None of the five youth were identified as needing emergency care upon admission. The chronic conditions list was reviewed and one additional youth record was identified for a youth with a chronic condition identified upon admission and the youth's IHCR had documentation the DHA was notified of the youth's admission and condition.

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

Five youth individual healthcare records (IHCR) were reviewed and each included a new Health-Related History (HRH) completed on the day of admission by a registered nurse. The process to complete the HRH at admission was verified through an interview with the health services administrator. Each of the five IHCRs contained documentation indicating the designated health authority reviewed the HRH.

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

The program has a policy and procedures regarding the completion of the comprehensive physical assessment (CPA), including the requirement to clearly document the youth's refusal of any part of the exam on the CPA form accompanied by the youth's signature. The policy outlines the required Tuberculosis screening process. Five youth individual healthcare records (IHCR) were reviewed and each contained a new CPA completed within seven days of admission by the designated health authority (DHA). Each CPA was completed, as required, with clear documentation for any part of the exam which was refused by the youth including the youth's signature. Each youth's CPA included results from one verified tuberculin (TB) skin test completed within the last year which matched the results documented on each youth's infectious and communicable disease form. An interview with the health services administrator verified each youth receives a TB test yearly and follow-up x-rays, if needed and ordered by the DHA.

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

Five youth individual healthcare records (IHCR) were reviewed and found each youth was screened and evaluated for sexually transmitted infections (STI) upon admission. Each of the five youth were referred for further testing based on the results of their STI screening. The results of the testing were documented on the infectious and communicable disease (ICD) form and lab results were maintained in the corresponding section of the IHCR. None of the youth were out of the physical custody of the program requiring a rescreening for STIs.

Each of the five youth were also screened for human immunodeficiency virus (HIV) upon admission and offered counseling and testing. Three of the five youth consented to HIV testing and a signed consent form was found in the IHCRs. The results of the HIV testing were maintained in the youth's IHCR in a sealed envelope marked "Confidential" and signed by the designated health authority (DHA). Each of the three youth's health education records indicated the youth were given pre and post-test counseling. None of the youth consented to the release of the test results. The program utilizes a provider with a Department of Health certification to conduct the HIV tests. The program does not identify the youth's HIV status on the internal alert system and only releases the information to required parties. Each of the five interviewed youth verified they could ask for an HIV test at any time.

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

The program has a policy and procedures in place for the provision of sick call and monitoring of youth in restricted housing. The program conducts sick call twice a day, Monday through Friday, and once a day on the weekends, which exceeds the program's contract requirements for sick call frequency and is only conducted by a registered nurse (RN). The hours for sick call are posted on the youth dorm and on the entrance to the medical office. Five youth individual healthcare records (IHCR) were reviewed and one IHCR was applicable for a sick call during the annual compliance review period. Two additional youth IHCRs were reviewed. Each of the three applicable youth requested sick call on the Sick Call Request form, which was placed in the program sick call box. Each of the youth's sick calls were completed by an RN and documented on the sick call request form, which is maintained in reverse chronological order in the IHCR progress note section. The sick calls documented all required information, were listed on each youth's Sick Call Index, and were found on the program's Sick Call Referral Log. None of the reviewed youth presented with three or more instances of the same complaint.

The program's policy outlines the requirement for supervisors to review sick calls when nursing staff is not on-site. A program tour verified sick call forms were available to youth and the program has an exam table to conduct sick call in the medical office. Three of the five interviewed youth reported they would be seen by a nurse immediately if they submitted a sick call and two reported they would be seen within one day. All five interviewed staff reported the nurse reviews and conducts sick calls.

The program utilizes restricted housing, including controlled observation. The program's policy outlines the requirement for nursing staff to check in with youth in restricted housing at least once a day. An interview with the health services administrator (HSA) verified if nursing staff is not on-site, the direct care supervisor must check in with the youth. Five IHCRs were reviewed, of which four were applicable for restricted housing. Each of the four applicable IHCRs documented the nurse checked on the youth at least once each day they were in restricted housing to ensure the youth's medical needs were being met.

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

The program has a policy and procedures for the provision of episodic and emergency care. The program maintains a list of emergency numbers in master control and the medical office, which are inaccessible to youth. Five youth individual healthcare records (IHCR) were reviewed and four were applicable for instances of episodic care. Each of the four IHCRs indicated all episodic care was conducted by a registered nurse (RN) and documented, as required, in the youth's progress notes. The program reported there have been no instances of episodic care conducted by non-healthcare staff during the annual compliance review period; however, the program has nursing protocols in place for care administered by non-healthcare staff. All instances of episodic care were found on the Episodic Care Log.

The program has five first aid kits, two suicide response kits, and one automated external defibrillator (AED). The five first aid kits are located in the West sub-control, East sub-control, two vans, and the kitchen. An interview with the health services administrator (HSA) verified the kits are monitored by nursing staff monthly and upon use to ensure all approved contents are maintained and replenished, as needed. All checks were documented on the first aid kit check log by the RN who completes the verification. Three first aid kits were reviewed, West sub-control and each of the van kits, and confirmed the kits were fully stocked with contents approved by the DHA. The AED is located in the staff breakroom and accompanied by the AED instructions. The AED checklist verified the nursing staff checks the AED weekly. The AED was found to have batteries which expire on November 30, 2021 and were last changed July 31, 2020 and pads which expire on June 30, 2021 and were last changed May 10, 2020.

The program's Continuity of Operations Plan (COOP) requires quarterly medical drills to be conducted with AED and cardiopulmonary resuscitation (CPR) practiced at least annually. Announced and unannounced medical drills were found to be completed each month on all three shifts and documented, as required. One drill on each shift during the annual compliance review period was found to include the use of AED/CPR. Five pre-service and five in-service staff training records were reviewed and each was found to have training in first aid/CPR/AED. In addition, training records supported supervisory staff were trained in the administration of the epinephrine auto-injector. Each of the five interviewed youth reported they can see a doctor and dentist, if needed. All five interviewed staff reported they could personally call 9-1-1 in the event of an emergency.

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

Five youth individual healthcare records (IHCR) were reviewed and one was applicable for off-site care; therefore, two additional youth IHCRs were reviewed. Each of the three applicable IHCRs documented parental notifications were made upon determination off-site care, as required. The Summary of Off-Site Care form was utilized for each instance of episodic care and filed in the youth's IHCR. The designated health authority reviewed the Summary of Off-Site Care form and all discharge paperwork for each of the three applicable youth. Two instances required follow-up care and there was documentation the program scheduled and tracked follow-up referrals and visits as necessary for one instance of care. In the other instance of follow-up care, the youth's parent/guardian refused the follow-up treatment.

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

Five youth individual healthcare records (IHCR) were reviewed and two were applicable for a chronic condition; therefore, one additional IHCR was reviewed. Each of the three youth were identified upon admission with a chronic condition for a physical condition, was assigned the appropriate medical grade, and received periodic evaluations at least every ninety days, as required. The periodic evaluations were conducted by the designated health authority (DHA) and documented in the youth's progress notes. Each of the three youth's Department's Problem Lists reflected the youth's chronic condition. There were no lapses in medical care identified. No youth were applicable for anti-Tuberculosis medication during the annual compliance review period. Each youth applicable for a chronic condition was placed on the program's internal alert list, which is used to track chronic conditions and periodic evaluations. Interviews with the DHA and health services administrator (HSA) confirmed the internal alert list is utilized to track youth with chronic conditions and necessary periodic evaluations. The facility administrator reported the nursing staff is involved in daily morning management meetings to share pertinent medical information for youth in the program.

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

The program has a policy and procedures regarding medication management. Five youth individual healthcare records (IHCR) were reviewed and three were applicable for taking medications while in the program. Two of the three applicable youth were admitted to the program on medications and each of the two had documentation indicating the medications were verified, as required, and documented on the prescription medication verification checklist. There was documentation in both applicable youth IHCRs reflecting the DHA and psychiatrist were contacted to continue the medications. All three IHCRs applicable for medications had documentation in the IHCR indicating all medications were administered pursuant to a valid order and prescription by the DHA or psychiatrist. Any changes or new medications were placed

in the youth's orders by the DHA. None of the youth were applicable for over-the-counter medications not listed on the Authority for Evaluation and Treatment (AET).

The program utilizes the standard Medication Administration Record (MAR) which includes all required information. The MAR book was reviewed and found the nursing staff verified the six rights of medication prior to administration of all medication. Nursing staff initialed each administered medication entry. Nursing staff documented weekly side effect monitoring for each youth and each medication. There were no lapses or missed medication identified. Two youth were applicable for medications while in restricted housing and each received medication, as required. One youth was applicable for refused medication; the refusal was clearly documented on the MAR and a refusal form was found. The youth did not sign the MAR indicating refusal; however, the youth did sign the refusal form. Four of the five interviewed youth reported the nurse administers medication. The remaining youth reported they do not take medications. All five interviewed staff reported both nurses and supervisors can provide medication. The program reported no non-healthcare staff administered medication during the annual compliance review period; however, the program maintains a list of staff trained in the administration of medication. One medication pass was observed during the annual compliance review. The nurse maintained control of the medication cart while a direct care staff supervised the youth. The nurse verified all required information, educated the youth on the new medication, administered the medication, and initialed the MAR.

The program stores all medication in the locked medical office. Youth medications are stored behind a separate locked door in the locked medication cart, which was observed to be well-stocked and organized. Oral and topical medications are separated and all controlled medications are kept in a locked box in the medication cart. The program maintains a fridge in the medical office used only for refrigerated medications. The program's policy outlines the process for the destruction of medications, which was confirmed through an interview with the health services administrator (HSA). Medications are destroyed by the HSA with a witness and controlled medications are secured then destroyed by the consultant pharmacist.

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

The program has a policy and procedures in place for medication storage, inventory and destruction of medication. An interview with the health services administrator (HSA) confirmed the program's policy for the destruction of medications; medications are destroyed by the HSA with a witness and controlled medications are destroyed by the consultant pharmacist. The program stores all medication in the locked medical office. Youth medications are stored behind a separate locked door in the locked medication cart, which was observed to be well-stocked and organized. Different medication types are kept separate, and all controlled medications are kept in a locked box in the medication cart.

The program maintains a fridge in the medical office used only for refrigerated medications. Over-the-counter medications (OTC) are maintained in the medication cart and sharps are maintained in locked drawers in the medical office. All medications, OTC medications, and sharps are inventoried on a perpetual and weekly basis and no discrepancies were found in the inventory logs during the annual compliance review period. The HSA reported if there was a discrepancy, an investigation would be initiated and the discrepancy would be reported to

program administration and the Central Communications Center, if applicable. The controlled medications for each youth are inventoried on both the Individualized Controlled Medication Inventory Record and the youth's Medication Administration Records (MAR) on each shift, prior to the morning medication pass, and during medication administration by two staff. Whenever the program receives new medication from the pharmacist or upon the youth's admission, the count is documented, as required. Counts for three sharps, three OTC medications, one youth medication, and one controlled medication were conducted with the nurse and all counts were found to be accurate and matched the perpetual inventories maintained by the program.

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

The program has infection control and exposure control plans and procedures. Both the exposure control and infection control plans were reviewed by the designated health authority (DHA) on February 28, 2020, and the facility administrator (FA) and nursing staff on March 6, 2020. The infection control plan includes all required information, including a comprehensive process for post-needle stick exposure evaluation.

A review of five pre-service staff personnel records found staff are offered the Hepatitis B vaccine upon hire. Observations during the annual compliance review confirmed staff have access to protective equipment. The program's exposure control plan is maintained in master control and is accessible to all staff, which was confirmed through an interview with the FA. The exposure control plan was written in accordance with Occupational Safety and Health Administration (OSHA) standards and includes all required information on risk assessment and methods of compliance. The program maintains a separate file to maintain any documentation of facility/occupational exposure, which is kept for ten years. The program reported two instances of infectious diseases which were reported to the Central Communications Center, as required. The program did not have three or more cases of reportable infectious diseases or any instances of quarantining or hospitalizations of ten percent or more of the population.

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

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

4.19 Licensed Medical Staff (Critical)	Satisfactory Compliance
The designated health authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according Department Rule, as well as facility operating procedures and nursing protocols approved by the DHA.	

The program utilizes four registered nurses (RN) to provide medical care at the program, one of which serves as the regional clinical director and one who serves as the program's health services administrator (HSA), which meets the contract requirements for healthcare staff. Each RN has a clear and active license in the State of Florida, three of which expires on April 30, 2021 and one which expires on July 31, 2022. Each RN also has a current cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) certification.

Standard 5: Safety and Security

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

The program has a policy and procedures indicating program staff shall maintain active supervision of youth, including interacting positively with youth, engaging in a full schedule of constructive activities, closely observing behavior and changes in behavior of youth, and consistently applying the behavior management system (BMS). The program's staff to youth ratio for day time is 1:6 and sleeping 1:10. During the annual compliance review week, the staff were observed during daily activities, such as school, recreation, breaks, line movement, and treatment team.

Staff displayed positive interactions with the youth, implementing the BMS by addressing negative behaviors immediately, closely monitoring each youth by providing active supervision, without allowing youth to roam freely. When staff were asked the amount of youth they were supervising, each was able to provide an accurate count of youth. Three staff were asked to explain the procedures when the youth count cannot be reconciled. All three indicated master control is notified, a code is called to stop all movement, and an emergency count of youth is conducted. Two staff stated if unable to locate the youth, a search is conducted. One staff said the doors and gates are checked, a perimeter is set up, and if unable to locate the youth, 9-1-1 will be called, as well as the Central Communications Center (CCC).

The activity schedule was observed in the youth module and provided an agenda of daily activities to engage the youth. A review of video coverage of six different one-hour increments of youth in their sleeping rooms was conducted for a total of thirty-six fifteen-minute checks. Three discrepancies were found in regard to supervision of the youth; two checks were not completed, as recommended, and one fifteen-minute check had not been completed to encompass all of the youth in the module.

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

The program has a policy and procedures detailing the program's behavior management system (BMS). The youth handbook also describes the BMS in detail. The program's BMS includes to maintain order and security, to promote and protect youth rights, opportunities for positive reinforcement, positive and negative consequences, constructive disciplinary actions, recognition of accomplishments, and positive behaviors at a ratio of 4:1. The policy further details the promotion of socially acceptable means for youth to meet their needs, a process for

explaining to youth the reason for any sanction imposed, the opportunity for youth to explain their behavior, and for the youth and staff to discuss the impact of the behavior on others, as well as reasonable reparations for harm caused to others.

The BMS contains discussion conducted with youth of alternate behaviors, promotion of positive dialogue and peaceful conflict resolution, coordination with the individual behavior plan, and consistent implementation and treatment through oversight. The separation of youth from population is minimized, and the BMS does not include an increase of length in stay, denial of youth basic rights or services, promotion of group punishment of youth by other youth, or disciplinary confinement. The negative consequences are in direct relation to the severity of the inappropriate behavior exhibited. The BMS is not posted; however, it is clearly documented in the youth handbook, which was reviewed with each of the five youth on the day of admission and documented in the case management record.

The agreement between the Osceola County School Board and the program addressing the BMS was approved on July 26, 2016. The BMS had not been changed since the last annual compliance review. During the annual compliance review period, the staff were observed displaying positive interactions with the youth, implementing the BMS by addressing behaviors immediately. A review of the program's canteen order forms, and BMS tracker forms indicated the staff keep daily track of youth's behavior, and provide points and earned incentives, when applicable. The program utilizes nightly privilege, Super Monday, Phat Friday, and Gotchas as incentives for youth to earn points on a daily basis.

A treatment team was observed during the annual compliance review week; the treatment team members discussed the youth's behavior, as well as positive or negative consequences. Five youth were interviewed regarding the consequences used in the program, and the process for receiving consequences, as well as staff consistency in what behaviors are punishable. Three of the five youth indicated early bed time is a punishment. Two youth revealed loss of points is a consequence and is given when not following rules, as well as receiving a twenty-one-day punishment for participation in fights, which means being unable to receive incentives or move to the next level. One of the five youth indicated having been placed in a closed room following an altercation with another youth; the youth was on controlled observation due to aggressive behavior. The five youth were asked how they are rewarded in the program and all stated through incentives. Four indicated canteen and one mentioned a later bed time is a reward. One youth also stated receiving rewards for most respectful and most helpful.

One of the five staff interviews indicated the program's BMS is a point system, another said a level system. One mentioned the BMS uses rewards and consequences at a 4:1 ratio. One of the five staff stated the BMS is posted throughout the facility, and another said it is included in the youth handbook and provided during the orientation process. All five staff interviews indicated the program utilizes incentives as part of the BMS and nothing can be taking away from a youth as a consequence. One staff also mentioned Gotcha pizza parties are incentives, and another stating canteen, Mega Monday and Phat Friday.

The facility administrator (FA) interview indicated the program utilizes a token economy as part of the BMS. The youth can earn points based on behavior; with theses points they can purchase canteen and "make their day." If the youth make a certain number of days, they are able to earn their level to move forward in the program. The FA indicated the program has several ways of ensuring rewards outnumber the consequences 4:1. They use Gotchas when a youth is doing well; twenty Gotchas earn a youth food from a local restaurant. Youth can also earn points to receive daily incentives, as well as Mega Monday and Phat Friday.

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

The program has a policy and procedures indicating oversight of the behavior management system (BMS) is assigned by the facility administrator (FA). The FA or designee ensure staffs' knowledge and implementation of the BMS, as well as each staff members skills are assessed during the annual performance evaluation. The BMS includes a process wherein staff explain to the youth the reason for any sanction imposed prior to the end of the work day, the youth is given an opportunity to explain behavior, and staff and youth discuss the behavior impact on others, as well as reasonable reparations for harm caused to others, and alternative acceptable behaviors. The program does not utilize room restrictions. A review of the program's position descriptions for those staff whose job functions include the implementation of the BMS, indicated the program has a general description of the qualifications necessary. Five in-service and five pre-service training records were reviewed indicating all ten staff had received training in the program's BMS. The assistant FA conducted the training in the jointly combined BMS plan for the educational staff.

Five interviewed staff indicated youth are informed of consequences and are able to explain their behavior through discussion/conversation. One of the five staff said the youth are given multiple opportunities to address the issues identified, if unsuccessful, they are directly informed of the consequences and given an opportunity to explain their behavior. Each of the five interviewed staff indicated they are informed of consequences and are able to explain their behavior through discussion/conversation. Two of the five staff indicated they are provided feedback regarding implementation of the BMS during shift meetings and through daily conversations about the individual youth and their behavior. Additionally, one staff stated multiple discussions between supervisor, staff, and therapist occur and another added, supervisors have a collaborative process with staff regarding behavior issues and the implementation of point levels, and incentives.

All five youth interviews indicated the program runs on a level system; four youth stated progress through the levels by following the rules and going to school and groups. Additionally, one youth stated there are nine levels, and another more than eight, with one youth being unsure. All five youth indicated none of the youth is ever allowed to punish another youth, staff hand out rewards the same, and they all think the program's BMS is a good system. The FA advised youth consequences are monitored through reviews during treatment team and the daily morning meeting. The FA stated the shift manager conducts a review of the point system and the BMS tracker each shift to see if further action is needed to ensure staff implement the BMS consistently. The number of youth who accomplished the daily goal is reviewed during the daily morning meeting.

5.04 Ten-Minute Checks (Critical)	Limited 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 maintains 108 cameras for the program and each of the cameras were in operation while on-site during the annual compliance review. The program's policy and procedures indicate ten-minute checks shall ensure staff observe youth at least every ten minutes while the youth are in their rooms, either during sleep, rest periods, or other times they are in their room. A review of ten-minute checks was completed on a sample of six randomly selected dates and times, capturing each of the three shifts on the Suns module. Three of the six one-hour samples had no exceptions. In addition, all checks during all six samples were completed on time with the exception of one which was completed five minutes late.

During one of the other three samples, one staff member conducted the checks by walking down the middle of the module glancing from side to side at the youth's closed doors making it unclear if the check was conducted properly, as well as one visual room check missed during this check time. During the annual compliance review, when this video footage was reviewed with administration, administrative staff indicated during the timeframe of this check, youth's lights are still on and youth are often standing at the door. As a result of this observation, the staff member received an immediate written reprimand. On a separate ten-minute check, a different staff member walked down the module going from door to door with his flashlight, where the room lights were out; however, the staff member did not shine the flashlight into the room window when doing checks. This staff completed checks this way for two sets of ten-minute checks during the hour reviewed. A third staff member started the ten-minute checks on time; however, only completed the first few rooms of the checks, leaving the last eight rooms unchecked. This staff member completed the ten-minute paper check sheet indicating all checks were completed on time. As a result of this observation during the annual compliance review, the Central Communications Center (CCC) was contacted and a report of falsification was reported. This staff member was terminated the following day as a result. The three staff members who completed the above checks improperly were hired within the last forty-five days and were each trained on the ten-minute check process during pre-service training. In addition, the program discusses the ten-minute check process during the all-staff meetings.

The program has a process in place to conduct fidelity checks of the ten-minute checks. Through interview with administrative staff, it was indicated administration randomly conducts fidelity checks during non-traditional hours; however, this process is not documented. It was verified in the logbook administrative staff do enter the program during non-traditional hours. The shift supervisor conducts one set of ten-minute checks and reviews the staff member's ten-minute checks during each shift. This process was observed and found documented in red ink on each ten-minute check sheet. The assistant facility administrator conducts random video reviews of ten-minute checks each day; however, is not documented. In addition, corporate staff conducts quarterly quality assurance checks of the program which incorporates a review of ten-minute checks. All five interviewed staff indicated ten-minute checks are conducted every ten minutes. One of the five also added, most are completed every eight minutes.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day.

The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.

The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is feasible after order has been restored.

The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.

The program's policy and procedures state staff shall conduct and document counts minimally at the beginning of each shift, after each outdoor activity and during emergency situations such as escapes or riots. Through observations of counts and a review of the program's logbooks, it was validated counts were conducted, as required. The observed youth counts conducted by master control was observed, as well as the staff on video as the counts were conducted. Master control called the count for each area youth occupied. The master control staff counted the youth on video to verify the count matched what was reported. Each staff physically counted the youth and provided the count and indicated if any youth were out of the program or when youth were in treatment team or with a therapist. The logbooks documented counts were conducted at the beginning of each shift, after outdoor activities, and during an emergency. The logbooks documented when youth were temporarily away from the program during the head counts and census counts. Census counts were captured in the logbook, as well as on the whiteboard in the administrative conference room. In addition, the number of youth away from the program was documented on the whiteboard. Each of the five interviewed staff indicated counts are conducted every hour and after every movement. Four of the staff were able to state the current census of sixteen; one staff was not able to provide the information.

5.06 Logbook Entries and Shift Report Review	Satisfactory Compliance

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

The program has a policy and procedures addressing logbook entries and shift report reviews. A review of the logbooks since the last annual compliance review was conducted. The logbooks were bound with numbered pages, entries were made in ink, with no erasures or white outs, and no entries had been destroyed or removed. All but one error observed were struck through with a single line and initialed by the staff member making the error. The one error observed was documentation indicating zero Central Communications Center (CCC) reports were made, but was then struck through and the information was modified to reflect one incident was reported to the CCC. The staff making the correction did not initial the entry. All other entries included the

date and time of the event, the name of the staff and where necessary, the name of the youth involved, a brief description of the event, and the signature of the staff making the entry.

The master control logbook included documentation of emergency situations, incidents, special instructions for supervision and monitoring of youth, population counts at the beginning and end of each shift, and any other population counts conducted during each shift. The documentation in the logbook covered perimeter security checks, transports away from the facility, requests by law enforcement to access a youth, removal of any youth from the mainstream population, and admissions and releases, including the name, date, and time of arrival or departure. The program documented all but one CCC report in the logbook since the last annual compliance review; the program indicated this was an oversight. The program maintains one logbook at master control, as well as shift reports which are maintained at sub-control in the living unit for one week. The program summarizes the events, incidents, and activities documented in the program's master control logbook in the shift report. A shift briefing was observed during the annual compliance review week. During the shift briefing, the supervisor verbally briefed the incoming staff about the contents of the shift report and had all staff sign the report acknowledging receipt of the information.

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

The program has a policy and procedures including key assignment and usage, as well as 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 program's method for the daily tracking and reconciliation of keys is the responsibility of the master control operator. The master control operator's duties include daily tracking and reconciliation of keys, conducting inventory, and distributing and collecting keys shift-to-shift. Observations conducted during the annual compliance review week included distribution and collection of keys, which are conducted by master control.

The program has three locked key boxes, one for restricted keys, one for education, and one for all other facility keys. All three boxes are in master control, with the master control operator having exclusive access to the boxes. The boxes were found to be locked while not in use. An observation included staff entering the facility and providing master control their personal keys, as well as personal cell phone for safe keeping. The cell phone is placed in an over-the-door-shoe organizer, which has small mesh pockets. The keys are placed in the spot of the key they are assigned to for their shift. The staff sign the key control log which documents the date, the name of the staff and signature, the keys signed out, and key signed in, as well as time the key was signed out and signed back in. There are several key control logs; visitors, teacher, and other staff. When visitors enter the facility, visitors sign in and provide their personal keys to master control to be placed in a small mesh pocket and in return, get a chit/token. When the visitor leaves the facility, the chit/token is exchanged for personal keys upon signing out. A

review of the teacher key control logs since the last annual compliance review found discrepancies.

During observations of key collection one education staff signed in a key with a different number then what was on the teacher key control log. The key control log had pre-printed names of education staff and the key number they receive, so the education staff only needed to document the in/out dates, times, and sign. The program indicated the key provided to the education staff is one which opens doors necessary for daily operation of the education department. The regular staff assigned to the key was not going to be on-site and; therefore, another staff received the key. The program made an immediate change to the teachers key control log to reflect the correct number of the key. Further observation of the teachers key control logs indicated the pre-printed sheets had been offset between the key number signed out and key number signed in by one number, which meant staff signing out key one would sign in key two, and staff signing out key two would sign in key three, and so on. The program immediately, upon receipt of this information, corrected the pre-printed sign in and out sheets to reflect the correct information. This error occurred for the past three months on all of the teachers key control logs. The master key inventories were observed. The program has permanently assigned keys for their administrative staff, whose keys are authorized by the facility administrator (FA).

The program maintains master inventories for all keys assigned daily, to floor staff, case management, therapists, education staff, as well as a key inventory for all restricted keys. Restricted key distribution occurs mainly in the morning when kitchen and maintenance staff arrive. Observations during the annual compliance review week indicated authorized staff will come to master control to sign out/in the restricted keys when necessary. The master control operator verified the practice in an interview, explaining the youth property locker keys are maintained in a special safe with a number lock. The safe is located in front of the assistant FA's office; only certain staff have the key combination. During the annual compliance review period, none of the keys had been damaged, lost, missing, or needed replacement; therefore, no Central Communications Center (CCC) reports were required. If a key needs to be replaced, the program has a contract with a Department-approved vendor. Three key rings were observed; all three staff had the correct key ring in their possession. All five interviewed staff indicated staff and visitor keys are given to master control upon entry, personal keys are securely stored, and chit/token is provided to the visitors. Staff confirmed there is a daily tracking of keys with a key log, as well as an inventory of keys. All five interviewed staff indicated youth do not have access to keys, and if a key goes missing master control is notified, and the facility and youth are searched. All five staff stated program keys are assigned to certain staff, and three of the five indicated if a key is damaged it will be replaced.

5.08 Contraband Procedure	Satisfactory Compliance

The program's policy must address illegal contraband and prohibited items.

A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.

The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.

The program has a policy and procedures addressing any staff found in the possession of contraband in the program will be subject to disciplinary action up to and including dismissal, as well as law enforcement being contacted for items considered illegal or if there is evidence of any type of unlawful activity. The policy includes a list of contraband items, such as sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal cellular devices, unauthorized currency, and personal keys, as well as exemptions to those items.

A list of contraband items, as well as consequences if found with contraband, is clearly documented in the youth handbook which is provided to each youth on the first day of admission, and this is documented in the youth case management record. A review of logbooks, search forms, and room search logs indicated the program conducted physical plant, facility grounds, youth, incoming and outgoing mail searches as defined by the policy. The program documents confiscation of contraband, as well as means of disposition on the search forms. During the annual compliance review period, no illegal contraband was located. The facility administrator (FA) indicated all illegal contraband is turned over to the sheriff's department, as indicated by the program's policy and procedures. Any contraband not deemed illegal is secured in the FA's office, photographed, and destroyed off-site when the investigation is completed.

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 addressing searches, including youth, program, and room searches. The policy indicates youth searches shall be conducted according to the Protective Action Response (PAR) training manual. Prior to conducting any search, staff shall prepare the youth by explaining the purpose of the search and what to expect while assuring the youth's safety. Staff shall avoid use of unnecessary force and shall treat the youth with dignity and respect to minimize the youth's stress and embarrassment.

During the annual compliance review week, observations of youth searches confirmed adherence to the policy. There were no admissions, off-campus activities, visitation, or youth tool utilization. Observations before and after treatment team, transports, and education confirmed searches were completed, as required. All five interviewed staff indicated youth searches are conducted during every movement. Each of the five interviewed youth stated they are searched when returning from off campus, after outdoor activities, when items are missing, and after meals. Four youth stated searches are conducted after visitation and one also indicated after work detail.

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

The program maintains two vans, which are utilized to transport youth. Both vans received an annual safety inspection on December 12, 2019 and March 3, 2020, respectively. The documentation for the inspection and other maintenance documents are maintained in a vehicle binder. The program is a high-risk program; therefore, requires either for the vehicles to be equipped with a safety screen separating the front seat from the back seat or a staff shall occupy the back seat with the youth. Each of the two program vans are equipped with a safety screen. One transport took place during the annual compliance review week and was observed by members of the annual compliance review team. The transport staff member completed a pre and post-inspection for the transport and indicated staff and youth wear seatbelts during every transport.

A review of the transport binder validated pre and post-inspections were completed for each transport, for the last six months. A random check of personal vehicles was conducted on multiple days during the annual compliance review; only one vehicle was found unlocked. The assistant facility administrator was present when this was discovered. This was addressed with the staff whose vehicle was left unsecured. An observation of each program vehicle validated each was equipped with a fire extinguisher, the appropriate number of seat belts, and a safety screen; neither had any equipment which would allow for a youth to be attached to the vehicle by any other means than a seatbelt. The doors to the youth passenger area could not be opened from the inside on either vehicle. An approved first aid kit was available for each vehicle and maintained in master control. Each set of keys, for both vehicles, contains a seat belt cutter and a window punch.

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

Through observations and a review of a youth transportation during the annual compliance review, it was validated the program is in compliance with the policy and procedures, as well as the Department’s policy. An interview with a staff who conducts youth transports, confirmed the

program provides a cell phone for use during transports and further indicated the staff to youth ratio is one staff to five youth; however, the staff indicated two staff always accompany a transport. A transport of one youth was observed during the annual compliance review. The vehicle being used was equipped with a safety screen. The youth was searched prior to and after the transport. Two staff were on the transport with the youth. One staff conducted an inspection of the vehicle prior to transport. Both staff and youth wore seat belts when exiting the parking lot. There is no means to attach the youth to the vehicle other than the seat belt. Upon return from the trip, the youth and both staff were wearing seat belts. The program-issued cellular telephone was retrieved prior to the transport. Both staff were the same gender as the youth transported.

The program completes a driver's license check of each designated driver. A review of driver's licenses checks validated checks were completed for the last six months. The program's policy and procedures state staff are not to leave youth unsupervised in a vehicle, nor are youth permitted to drive program or staff vehicles. During the annual compliance review period, neither of these instances were found to have occurred. When five staff were asked what safety equipment is in the program vehicles, five indicated a first aid kit, while three of the five also indicated a fire extinguisher. Five staff further indicated staff are not permitted to transport youth in their personal vehicles. The five staff stated the transport vehicles are searched for contraband prior to and after each use. The five staff also stated in the event of an emergency, their process is to call 9-1-1 first and then the program. All five staff indicated the ratio for any youth transport is two staff to one youth. When five youth were asked if they had ever seen anyone place contraband in a program vehicle, all five stated they had not. All five youth also stated they feel staff drive program vehicles safely.

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

The program has a policy and procedures outlining weekly safety and security audits which states the audits are to be completed by the assistant facility administrator (AFA) and reviewed by the facility administrator (FA), and facility management team within the daily meeting forums. In the event of an identified emergent issue, the findings will be addressed immediately with the leadership staff. As a result of identified safety and security deficiencies, corrective action shall be developed and implemented. Follow-up and verification of identified deficiencies and corrective action step completion shall be completed by the AFA and discussed during the daily management meeting.

The program's policy and procedures meet all requirements, as outlined by the Department's Rule. The weekly safety and security audit forms were reviewed since the last annual compliance review; audits were completed on a weekly basis, as required. The FA indicated the program completes key performance indicator (KPI) reports based on the information obtained during morning meeting reports to identify and track safety and security deficiencies. The information is totaled each month and compared to the previous month, then a management team meeting is conducted to plan how to reduce the amount of deficiencies. There are internal reviews completed by corporate staff to verify deficiencies are reduced.

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

The program has a policy and procedures addressing the issuance, inventory, and control of equipment, and tools, as well as a missing/lost tool procedure. When a tool is missing or lost, the facility administrator (FA) and the tool control officer shall be notified. A tag is hung on the shadow board until a replacement tool is in place. If a class A tool is missing during a work project or activities involving youth, the FA or designee is immediately notified and the staff supervising the inventory has to write an incident report. This will be documented in the master control logbook, and the Central Communications Center (CCC) is notified within the required timeframe. If a tool is damaged, it is properly disposed of, and a new one is acquired for replacement. The program prohibits the use of machetes, bowie knives, or other long blade knives.

Observations of tool storage during the annual compliance review week indicated the program maintains kitchen tools in a locked toolbox, in a locked cabinet, in the cook's locked office, and in the kitchen. A review of the kitchen tool inventory and the sign-in/out sheet indicated one tool was not present; a tong. The kitchen staff indicated the tong was currently in use and had not been signed out. The staff received a written reprimand as the result of these findings. The program maintains other tools in a small building on the facility grounds. The small building is locked, and only certain staff members have access to the key. The building houses tools and other maintenance materials. Some of the tools are maintained on a shadow board, others are in drawers in a large tool storage container, and items such as rakes and shovels were sitting against the wall or laying on the work bench. Most of the tools had small stickers with numbers on them, others the stickers seemed to have fallen off. A review of the tool inventory indicated all tools were present; however, tools were difficult to identify due to being unable to match the number with the tool. After this issue was brought to the attention of the program, a device to engrave all of the tools for easier identification was ordered, and a copy of the receipt was provided.

A review of class A tool daily and perpetual inventories, as well as a class B tool monthly inventories was conducted, which indicated they are completed as required. A review of the five pre-service staff training records indicated all received the required training on the intended and safe use of tools. Youth do not get training since they are only allowed to use mops and brooms. Five staff were interviewed. Three staff indicated youth are allowed to use mops and brooms when determined appropriate based on the safety plan. The other two staff stated youth do not use tools at all.

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 indicating youth are allowed limited access to class B tools. Youth are only allowed to use mops, brooms, dust mops, push brooms, dust pans, and mop buckets under the direct supervision of staff. A 1:5 staff to youth ratio shall be observed. Prior to using these a risk assessment will be conducted on the youth. The tool check in and check out log for all tools issued to staff shall be recorded on the shift report. All youth are frisk

searched following the use of tools. One of five youth interviews indicated youth are allowed to use mops and brooms, the other four stated no tools.

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 indicating private contractors shall receive written instructions detailing responsibilities regarding tool management and contraband and shall confine their work to the authorized area using safety and security precautions. Outside contractors shall be accompanied by the maintenance staff or designee and receive oral instructions regarding responsibilities for tool control and prohibition on bringing in contraband. In addition, staff shall supervise outside contractors in areas were youth are located. The facility administrator (FA) is responsible for providing approval/permission if items such as personal cellular phone, equipment/electronic devices capable of taking pictures, and audio/video recordings, including smart watches are needed to perform the work project. The program's Outside Contractor On-Site Work Project Log documents when a contractor comes on-site and includes tools checked upon arrival and departure, tool restriction while in the program, youth are restricted from the work area and a missing tool follow up. A review of six project invoices indicated the program completed an Outside Contractor On-Site Work Project Log and had each contractor sign in/out the visitor log.

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.	

A review of the program's approved Continuity of Operations Planning (COOP) was reviewed to determine the frequency of emergency drills. The program maintains a drill schedule for the year. The program conducts two COOP drills each month on random shifts, in addition to a fire drill each month on each shift. A review of drill documentation confirmed the drill schedule is followed. In addition, documentation confirmed two COOP drills were conducted each month for the last six months and a fire drill was conducted each month, on each shift, for the last six months. Each drill form contained the type of drill, date, time, participants, brief scenario, findings, and recommendations.

During the program tour, egress plans and evacuation routes were observed; one in administration, one in the Suns hallway, and one on the Suns dormitory. A review of eight fire extinguishers confirmed all were inspected January 2020, with the exception of one, which was located in sub-control on Suns dormitory and was inspected December 2018. The facility administrator indicated COOP drills are conducted monthly. Five interviewed youth stated they have been instructed on what to do in case of a fire. Two youth stated fire drills are conducted once a month, one youth was not sure, but thinks every two months, one youth stated every forty-five days, but was not certain, the other youth stated he had been at the program over a month and has not participated in a fire drill. All five interviewed staff indicated they had participated in the following drills over the last twelve months: weather, major disturbance, bomb threat, hostage situation, chemical spills, escape, fire, and medical.

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

The program maintains a program Continuity of Operations Planning (COOP) which is located in the facility administrator's (FA) office and in master control, which is accessible to staff at all times. The program's COOP was reviewed and updated on March 18, 2020. The program's COOP was signed by the Department's regional director validating it was submitted and approved by the Department, as required. The program's disaster plan and COOP are one combined plan. The COOP addresses alternative housing plans which was approved by the Department's regional director. The program's COOP is in the new format and contains all required elements. In addition, the COOP contains two annexes which were updated February 26, 2020.

The program maintains a provision of equipment and supplies required for continuous operation and services during emergency or disaster situations, which is located in the kitchen area. The supplies consisted of food supplies and water, designated for these purposes. The assistant facility administrator was interviewed and indicated the COOP is located in master control and in the FA's office. The program maintains an administrative hard copy of youth information in event of emergency. This binder was observed and located in the program's master control. The binder contained all required information for each youth.

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 maintains a policy and procedures which states all flammable, toxic, caustic and poisonous materials shall be stored in secure areas inaccessible to youth. All such chemicals are stored in three separate locations, one area is located outside of the facility in a locked storage building; while the other two are located inside the facility behind locked doors. All three locations were observed during the annual compliance review, which validated the locations were secure at all times and inaccessible to youth.

A review of the chemical inventories validated inventories were maintained monthly and after each use. The inventory was reviewed and compared to three items in each of the three storage areas, where each item matched what was documented on the inventory. The program maintains a list of staff, who are permitted to handle and have access to chemicals, and their positions. This information was located on the outside of the chemical storage door, as well as maintained in administration. The list documents the maintenance staff's name and the facility administrator's name. The program maintains safety data sheets (SDS) for the chemicals on site. The SDSs were compared with the inventory, three specific items, to determine if the

facility maintains SDSs for the chemicals on-site. The review validated SDSs were on-site for all three items.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program shall maintain strict control of flammable, poisonous, and toxic items and materials. *Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.* *The program shall establish and implement cleaning schedules, a pest control system, a garbage removal system, and a facility maintenance system which shall include maintenance schedules and timely repairs based on visual and manual inspections of the facility structure, grounds, and equipment, which shall be conducted bi-weekly, monthly, quarterly, semi-annually, yearly, and every three years, as prescribed in the Preventive Maintenance Checklist (RS 123, February 2019.*	

The program's policy and procedures indicate program youth shall not be permitted to use, handle, or clean with dangerous or hazardous chemicals, respond to chemical spills or clean, handle or dispose of any other person's biohazardous material, bodily fluids or human waste. The program staff ensures the youth are not in control of any such chemicals. During the annual compliance review, the areas where such items are stored was always secure and inaccessible to youth. Youth cleaning the dormitory was observed during the annual compliance review and it was determined the youth do not handle any of the chemicals. At no time during the annual compliance review were youth observed cleaning or handling, dangerous or hazardous chemicals; nor were youth observed cleaning, handling, or disposing of any person's bio-hazardous material, bodily fluids, or human waste. The program maintains a Preventive Maintenance Checklist and each month for the last six months, the checklist was reviewed to ensure maintenance schedules and repairs were conducted, as required. The checklists contained a list of items requiring weekly, monthly, and quarterly checks and each check was conducted, as required. All five interviewed youth indicated they do not use any chemicals or cleaning products.

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

The program has a policy and procedures which states only maintenance 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 maintains a list of staff and their positions, who are permitted to dispose of such items and materials. These staff receive training on the disposal of hazardous items and toxic materials upon hire. According to the program's policies and procedures, the disposal of hazardous items and toxic substances or chemicals is in accordance with Occupational Safety and Health Administration (OSHA) standards. The disposal of hazardous waste, the kitchen grease, is disposed of by a bio-hazardous waste contractor. The grease trap, which is located

outside of the kitchen area, was last disposed of by the disposal company on July 17, 2020. The program did not have a disposal log, as the program has not disposed of any such items since the last annual compliance review. The business manager, who oversees maintenance staff, indicated chemicals are used in their entirety; therefore, the program does not require chemical disposal. She further stated the kitchen grease is placed in a kitchen grease trap/disposal container for an outside business to retrieve and dispose.

The program maintains safety data sheets for all chemicals; however, none were disposed of during the annual compliance review period. When the program has liquid waste from work details, it is disposed of in the plumbing drains; and kitchen liquid waste, except grease, is disposed of in the kitchen. The program follows the required actions, which is part of their policy and procedures, for any chemical spills. The facility administrator indicated the program only purchases what is used and has not disposed of any items since the last annual compliance review.

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

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

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

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

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

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

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

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

The program has a policy and procedures addressing visitation, youth mail correspondence, and usage of the telephone, as well as alternative visitation arrangements with the parent/guardian. The policy indicates youth are allowed a minimum of one outgoing telephone call a week, which a review of the telephone logs validated the process. The visitation schedule was not observed posted during the annual compliance review. Due to the COVID-19 pandemic, in person visitation was suspended from March 16, 2020 – August 30, 2020. During this time, the program started a virtual visitation program with the youth and their families, where the youth were able to have face-to-face video calls for fifteen minutes each week through software applications including Skype, Duo, or FaceTime. The case managers set up and supervised the virtual visitation between each youth and family. All youth were able to participate in this weekly, and the program assured both the families and youth's safety and well-being. The director of case management advised virtual visitation was documented in each youth's chronological notes upon completion. The program did not house any youth with a history of human trafficking. A review of the correspondence and mail log indicated incoming, as well as outgoing mail is searched in the presence of the youth and all contraband is removed. Youth search documentation and visitor sign-in/out logs were reviewed indicating searches were conducted after visitation concluded. All five interviewed youth indicated they can communicate with family telephonically or by mail.

5.23 Search and Inspection of Controlled Observation Room	Satisfactory Compliance
The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.	

The program has a policy and procedures indicating controlled observation may be used as an immediate short-term crisis management strategy when a youth's aggressive, violent, or potentially dangerous behavior substantially threatens the physical safety of others, compromises program security, and when non-physical interventions would not be effective. Controlled observation shall not be used as a form of punishment or discipline. The program utilizes the youth rooms for controlled observation. The rooms meet the criteria of a minimum of thirty-five unencumbered square feet, a metal door with a shatter-resistant window, and vents which are not easily accessible and covered with small mesh. The room has a fire-retardant plastic mattress, light fixtures covered with shatter-resistant material, windows covered with security rated screen, and there are no electrical outlets, or electrical switches inside the room. The program had twenty-six controlled observations in the last six months; five were reviewed. In all five controlled observation incidents, the staff conducted an inspection of the room and a staff of the same gender conducted a search of the youth prior to placing the youth in the room alone.

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

The program has a policy and procedures indicating the facility administrator (FA) designates supervisory or higher-level staff to approve placement of youth in controlled observation. The program had twenty-six controlled observations in the last six months; five were reviewed. In all

five incidents, the youth did not exhibit behaviors indicative of a mental health crisis or suicide, and the placement was authorized by a higher-level staff. All five youth experienced active aggression toward others, and staff advised the youth for the reason of the placement, and the expected behavior for removal. In all five incidents, a healthcare professional completed a health status checklist. Each of the youth stayed in controlled observation ranging from one hour and forty-five minutes to nine hours and forty-five minutes. In three of the incidents, the youth remained in controlled observation for more than two hours and the FA or designee granted an extension for further placement at a minimum of every two hours thereafter.

5.25 Controlled Observation Safety Checks Release Procedures	Satisfactory Compliance
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 has a policy and procedures indicating the facility administrator (FA), assistant facility administrator (AFA), shift supervisor, and administrator on-call are designated to approve controlled observation. The program had twenty-six controlled observations in the last six months; five were reviewed. In all five instances, the staff making the placement completed the first page of the controlled observation report and submitted the report to the supervisor. Two of seventy-nine fifteen-minute checks were missed, all others were conducted, as required, and included documentation of the youth's behavior as observed. All safety checks and observations were documented on the Controlled Observation Safety Check form and the FA or supervisor gave written approval before a youth was released from controlled observation.

In all five instances, the Controlled Observation Report, the Health Status Checklist and the Controlled Observation Safety Check form were maintained in an administrative file but were missing from each youth's individual management record. The program acknowledged the forms are not placed in the youth's individual management record; however, moving forward the program will make this part of the process. In all five instances, the FA or assistant FA reviewed and approved the controlled observation report within fourteen days of the youth's release from controlled observation to determine if the placement was appropriate. The program indicated youth are removed from controlled observation when the safety risk no longer exists, which means none of the youth remain on an in-house alert.