STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Kissimmee Youth Academy
Youth Opportunity Investments, LLC
(Contract Provider)
2330 New Beginnings Road
Kissimmee, Florida 34744

Review Date(s): April 30 - May 3, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Bonita Williams, Office of Program Accountability, Lead Reviewer Standard 1
Pam Adams, Office of Program Accountability, Regional Monitor, Standard 5
Teresa Andersen, Office of Program Accountability, Deputy Regional Supervisor, Standard 2
Marvin Bliss, Office of Program Accountability, Regional Monitor, Standard 3
Melissa Johnson, Office of Program Accountability, Central Regional Supervisor, Standard 3
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor, Standard 4
Kamille Payne, Office of Program Accountability, Regional Monitor, Standard 5
Rowena Rose, Central Region DJJ Education Coordinator, Standard 2
Sherri Wilson, Office of Program Accountability, Technical Assistance, SPEP

Program Name: Kissimmee Youth Academy
Provider Name: Youth Opportunity Investments, LLC
Location: Osceola County / Circuit 9
Review Date(s): April 30 - May 3, 2019

MQI Program Code: 1426
Contract Number: 10287
Number of Beds: 71
Lead Reviewer Code: 148

Methodology

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

Persons Interviewed

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

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	*Ten Minute Checks	Failed
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	Failed
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handlins and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Recreation and Leisure Activities	Satisfactory
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Satisfactory
5.25	Controlled Observation	Limited
5.26	Controlled Observation Safety Checks and Release Procedures	Satisfactory

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Program Overview

The Kissimmee Youth Academy is a seventy-one bed program, for fourteen to twenty-one-year-old males (twenty-four mental health overlay and forty-seven Borderline Developmental Disability (BDD)/Developmental Disability (DD), located in Kissimmee, Florida. The program is operated by Youth Opportunity Investments, LLC, through a contract with the Department. The program provides Borderline Developmental Disability (BDD)/Developmental Disability (DD) and Mental Health Overlay Services. In addition, the program fosters each youth by providing Life Skills training (LST), Impact of Crime (IOC), Male Healthy (Relationship, Young Men's Work), Skillstreaming, and Trauma Focused Cognitive Behavioral Therapy. Additional treatment services provided includes gender-specific programming and recreation therapy. Program administration is comprised of a facility administrator, three assistant facility administrators, forty-three youth care workers, four unit leads, two unit managers, five shift supervisors, four master control, one recreational therapist, one physical plant manager, one transportation, one food service manager, three dietary workers, one clinical director, one director of case management, one health services administrator, and one assistant clinical director. Case management services are provided by five case managers and two transition case managers. Mental health staff at the program includes six therapists and one assistant clinical director. Medical health staff at the program includes a registered nurse clinical manager and registered nurse (RN), who are both on-site forty hours each week. On-site nursing coverage is provided seven days a week. Educational services are provided by the Osceola County Public School system. The layout of the program includes: one building which includes the living units, master control, school, administration, and nursing. The program has eighty-eight operating security cameras providing coverage. Of those, two were not working at the time of the annual compliance review; there is a work order pending. At the time of the annual compliance review, the program had thirteen vacant positions which include one therapist, one physical plant worker, two dietary workers, one master control, and eight youth care workers.

Strengths and Innovative Approaches

- They youth celebrated Earth Day at the program. The youth had the opportunity to learn the importance of Earth Day and went outside to plant a variety of vegetables in plastic plant containers.

- A district math coach spends two evenings a week at the program and works with six to eight young men for two hours on General Equivalency Diploma (GED) math prep. Youth are assigned an hour for class; however, most youth request to attend both hours. They have direct instruction from a district GED preparation teacher on working towards receiving a high school diploma through the GED test.

- The program was recently recognized by the Osceola County School Education Department. The Osceola County School Principal, and her staff appreciate the hard work and dedication the staff put forth to assist the youth. The program dedicated to working jointly with Osceola County School educators to provide the best environment for the youth. Program staff were presented with a bowl of assorted fresh fruits.

- Through a community partnership, the program welcomed a National Football League and Major League Baseball sports agent to speak to the youth. The agent represents several professional athletes and operates a successful law firm locally in Orlando. The topic of the day was “Sight vs. Vision.” After a brief motivational pep talk, the floor was open for the youth to ask whatever questions they had. The youth were eager to hear from someone who is involved in a field which many of them aspire to be in someday.

Standard 1: Management Accountability

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

The program has a policy and procedures for initial background screening process for newly hired staff. Since the last annual compliance review, the program had twenty-seven new staff. Of the twenty-seven new hires, eighteen had a background screening completed prior to their hire. The remaining nine had the background screening after their hire date, but before any contact with youth and completion of orientation and training. Each of the new staff had a completed criminal history review, Central Communications Center (CCC) history check, and were added to the program's Clearinghouse employment roster. None of the new staff were applicable for exemption. One of the twenty-seven staff had a break in service documented in the Staff Verification System. Twenty six of the twenty-seven new hires completed and passed the Diana Assessment, pre-employment tool prior to hire. The program reported, the remaining staff was a previous Eckerd employee and transfer of ownership took place August 1, 2016 and the tool was not a requirement at this time; however, the staff was hired on October 10, 2018. The program has not had any interns, mentors, or volunteers since the last annual compliance review.

The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Background Screening Unit on January 18, 2019. The teachers are paid by Orange County Public School system and received annual screening on January 7, 2019.

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

The program has a policy and procedures addressing the five year background rescreening process for all staff, volunteers, mentors, and interns. The rescreening is calculated from the date the staff was fingerprinted for the Clearinghouse. Further, the five year resubmission will be completed on or before the five-year anniversary of the individual staff's fingerprint card date, as required by the Department. The program had no staff eligible for five year background rescreening during the annual compliance review period.

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

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

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

The program has a policy and procedures ensuring the program provides an abuse-free environment for both staff and youth. During the facility tour, it was observed the Florida Abuse Hotline and Central Communications Center (CCC) numbers were posted throughout the facility. A review of seven staff records found each staff signed a code of conduct during orientation. In the last six months, the program had seven abuse allegations against staff. None of the allegations were substantiated.

Seven interviewed staff revealed youth are allowed to call the Florida Abuse Hotline. The staff reported they are to notify both the supervisor and facility administrator of youth wanting to call the Florida Abuse Hotline. The supervisors or unit mangers will assist the youth in calling. None of the seven interviewed staff reported observing a co-worker telling a youth they could not call the abuse hotline.

Seven youth were interviewed and reported feeling safe in the program. None of the youth reported ever having to call the Florida Abuse Hotline. All of the youth reported staff are respectful when speaking to them and have never heard staff using profanity towards youth.

The facility administrator reported the code of conduct includes, but is not limited to, theft, violence in the workplace, improper conduct, dress code, unethical/abusive behavior, and insubordination.

1.04 Management Response to Allegations (Critical)	Satisfactory Compliance

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

The program has a policy and procedures regarding management response to any abuse allegations. Documentation of five allegations were reviewed. For each of the allegations, there was documentation indicating management conducted investigations which included a review of

the incident report, video, and interviews with witnesses. In addition, the program, when necessary, removed staff from contact with youth pending investigation. The program implements a corrective action plan to address the situation. None of the abuse allegations were substantiated; therefore, disciplinary actions were not necessary.

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

The program has a policy and procedures regarding incident reporting to the Central Communications Center (CCC). In the last six months, the program had a total of twenty incidents reported to the CCC. Each of the five reviewed reports were reported within the two hour timeframe; however, during the annual compliance review, two additional CCC reports, not part of the sample, were not called in within the time frame. Both CCC reports included Failure to Report for staff. All CCC incidents were located in logbooks.

The facility administrator reported the standard practice is when a reportable incident occurs, the staff reports to the shift manager and the assistant administrative duty officer (ADO) for the report to be made.

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

The program has a policy and procedures for Protective Action Response (PAR)/physical intervention rate. The PAR training plan was reviewed and signed on January 9, 2019 by the Office of Staff Development and Training. The program submitted monthly PAR summaries to the Department by the fifteenth of each month for the last six months. The program's PAR rate during the annual compliance review period was .66, which is below the statewide residential PAR rate of 1.51. The facility administrator reported following the use of physical intervention, an interview is completed between the youth and staff. All PAR incidents are reviewed during the next day's management meeting.

In the last six months, the program had a total of twenty PAR reports. Five PAR reports were reviewed. In each PAR report, staff who were involved in the PAR submitted their report before the end of the workday. Each of the five reports were reviewed by the PAR certified instructor/supervisory staff and the administrator conducted a post-PAR interview with the youth. The facility administrator reviewed the PAR reports within twenty-four hours of the incident, which is earlier than the seventy-two hour requirement. None of the youth were injured as a result of the PAR; however, each youth was seen by the nurse as a precaution. The program maintains all PAR reports in the assistant facility administrator's office. All reports are to be added within forty-eight hours of facility administrator's review.

None of the PAR incidents involved mechanical restraint. None of the youth involved in the PARs made allegations of abuse; therefore, a call to the Florida Abuse Hotline was not necessary.

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

The program has a policy and procedures regarding new staff completing the pre-service/certification requirements. The pre-service training plan was submitted and approved by the Department's Office of Staff Development and Training (SD&T) on February 7, 2019. The program provides a combination of web-based and instructor led trainings. There was documentation all instructors, delivering trainings, were qualified as evident of certifications.

Seven staff records were reviewed for pre-service/certification requirements. All seven staff completed cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics (Standards of Conduct), suicide prevention, child abuse reporting, Prison Rape Elimination Act (PREA), and emergency procedures prior to any contact with youth. In addition, each of the staff completed additional training required by the program such as the grievance process, civil rights, safety security and supervision, and youth rights. All trainings were entered into the Department's Learning Management System (SkillPro) except for training for workers compensation for five of the seven staff, which was held during a staff meeting.

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

The program has a policy and procedures addressing the completion of twenty-four in-service training hours for staff. The program's in-service training plan was submitted and approved by the Department's Office of Staff Development and Training (SD&T) on February 7, 2019. The program provides a combination of web-based and instructor led trainings. There was documentation showing all instructors delivering trainings were qualified based on the certifications earned. The program has a current annual in-service training calendar for staff to follow.

Seven staff, which included three supervisors, in-service training records were reviewed. All staff completed more than the twenty-four hours of required training for the 2018 calendar year. The training included cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics (Standards of Conduct), suicide prevention, child abuse reporting, Prison Rape Elimination Act (PREA), grievance process, and other program required trainings. All three supervisors completed the required eight hours of supervisory trainings and the trainings were entered into the Department's Learning Management System (SkillPro).

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

The program has a policy and procedures for grievance process for youth. The grievance process includes three phases: informal, formal, and appeal phases. Youth can either fill out a Speak Out or a grievance form, both of which are located on the dorms for easy access. All grievances are maintained in a binder for twelve months and located in the assistant facility administrator's office. All staff are trained in the grievance process during both pre-service and in-service training. A review of their policy gave specific timeframes; however, states "shall be handled as expeditiously as possible."

All five grievances were completed within twenty-four hours of submission. None of the grievances went to the appeal phase. The assistant facility administrator (AFA) reviewed all grievances submitted by youth.

All seven staff interviewed were able to explain the program's grievance process. The process included knowing there are three phases to the process and who reviews the grievance with the youth, supervisor, or AFA. In addition, the forms are located throughout the program for youth access. Five of the seven youth reported knowing the forms are placed throughout the program, the other two did not respond to the question; however, they acknowledged knowing the grievance process. All of the youth responded they are able to request assistance when filling out the grievance forms.

The facility administrator reported youth have access to the grievance forms on the dorm. Once the forms have been filled out completely the youth will place the form in the grievance box in the hallway. The grievance box is checked each morning and reviewed during morning management meetings.

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

The program has a policy and procedures for delivery of delinquency interventions and facilitator training. The program provides Impact of Crime (IOC), Trauma Focused Cognitive Behavioral Therapy (TFCBT), and LifeSkills Training (LST) as their delinquency intervention services. All groups are incorporated in the program's daily schedule. The program has seven staff trained to facilitate groups, five in IOC and three in LST. There are six therapists who are trained in Trauma Focused Cognitive Behavioral Therapy. Each of the staff have at least one year of experience with working with juvenile offenders as evident of their applications/resume. Of the seven staff reviewed, six earned a bachelor's degree and one earned a master's degree.

Each of the seven reviewed youth performance plans incorporated delinquency intervention services. There is documentation in each of the youth records, as well as sign-in sheets indicating youth were provided delinquency services. At the time of the annual compliance review, four of the seven youth were in either IOC or LST. One youth had IOC at a previous program. The remaining two youth are not currently participating in delinquency interventions. The program reported the remaining youth are scheduled to receive IOC, which is scheduled to begin on June 10, 2019. All youth are attending TFCBT, as needed.

The facility administrator reported life skills training is delivered by a staff member who has been trained and holds a master's degree. Upon intake a classification meeting is held to determine which group will meet the youth's individual needs.

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

The program has a policy and procedures for the delivery of life skills training to youth while in the program. The program uses Skillstreaming as a life skill training for youth in the program. The program incorporated this group in their daily activity schedule. The program has seven staff who are trained in facilitating the Skillstreaming curriculum. All youth in the program receive Skillstreaming as a life skill service. This curriculum addresses communication, interpersonal relationships/interactions, critical thinking, and anger management. There was documentation in seven youth records participating in Skillstreaming groups as evident of progress notes and sign-in sheets. Seven interviewed youth reported receiving groups on various topics with the therapist. They learn about how to control anger and relationships. The youth reported using skills learned on the dorm and groups.

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

The program has a policy and procedures for youth to participate in restorative justice awareness activities while in the program. The program has youth participate in Impact of Crime (IOC) and complete restorative justice related activities. The program has five staff who have been trained in IOC. Two of the seven youth are currently in IOC groups and one completed the group at a previous residential program. The remaining youth are scheduled to attend the IOC group starting on June 10, 2019. The IOC group is part of the program's daily schedule. Youth are given the opportunity to sign-up for special restorative justice projects. The youth receive assistance from direct care staff and the supervisor confirms if the project was completed successfully. In addition, each youth is to complete community services hours while in the program.

The facility administrator reported the IOC groups are held every Wednesday and Friday and youth are required to complete community service projects.

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

The program has a policy and procedures for delivering gender-specific programming for youth in the program. The program facilitates male healthy relationships which includes Young Men's Work (YMW) and Teen Relationships. A review of sign-in sheets and progress notes found each group is conducted once a week and is incorporated in the program's daily schedule. In addition, the program has a group called Distinguish Gentlemen which teaches youth about becoming a young adult.

The facility administrator reported the program conducts Teen Relationships and Young Men's Work for gender-specific programming. In addition, the program has Distinguish Gentlemen which holds monthly dinners with guest speakers to talk to the youth about being a responsible adult.

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 regarding the process of entering and closing alerts in the Department's Juvenile Justice Information System (JJIS). Three of the seven reviewed youth records were applicable for alerts. All three youth had alerts requiring input in JJIS. Each of the alerts reviewed were entered into JJIS and the internal alert system and verified prior to entering. The annual compliance review team members confirmed youth who required alerts had alerts located in JJIS correctly and the alert information was also found in the logbooks. The program has an internal alert system which is updated as needed by the appropriate staff.

The facility administrator reported the clinical director, medical director and director of case management are responsible for entering and closing alerts. If there are any changes to alerts, emails are sent to all staff notifying them of changes. In addition, all alerts are reviewed during daily management meetings. All seven interviewed staff reported learning about alerts through the alert board, email, and debriefings.

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

The program has a policy and procedures addressing how youth records are to be set up. The program has set up youth records into to individual healthcare and case management records. Each youth record contained all required demographics and committing offenses on the inside and outside of the binder. The youth records had sections for legal information, demographic/chronological information, correspondence, case management/treatment team activities, and miscellaneous. Each youth record and file cabinets were labeled "confidential." All youth records were in file cabinets in a secured locked room only accessible to certain staff members.

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 addressing youth providing input into the program. The program has a student council committee and town hall meetings. The program has student council meetings twice a month and townhall meetings are held on a weekly basis. The program maintained meeting minutes from both the student council committee and townhall meetings. The minutes included sign-in sheets, follow-up on youth suggestions, and approved ideas. A review of the recreation and incentive calendars were part of the meeting minutes. A review of sign-in sheets and meeting minutes found meetings were held, as required.

The facility administrator reported each month there is a meeting with the student council members and during the meeting, youth can bring concerns and recommendations for the program. Youth also have the grievance process and request to speak for any other issues and recommendations.

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

The program has a policy and procedures regarding advisory board meetings, which are to include community members. The program conducted advisory board meetings on a quarterly basis. This was evident by sign-in sheets, agenda, and minutes from each of the meetings. The minutes document attendees such as former parents/guardians and youth, education, victim advocates, business community partners, judiciary staff (judges), and law enforcement. There was documentation of solicitation through emails and letters to community partners requesting their participation on the advisory board.

The facility administrator reported the advisory board meets quarterly. The program invites are sent to all required parties. At this time, the program is working on increasing attendance and solicit assistance from the community to start different projects around the program. The local Career Source Center, which is part of the board, partners with the program to conduct job fairs and hiring events.

One board member was interviewed and reported participation on the advisory board. The member stated she last attended six months ago and felt the meeting was very informative.

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 addressing communicating with staff regarding the program. The program has monthly all-staff meetings and daily management meetings where the staff are made aware of results from youth surveys, annual Department reports, and program planning; however, it was unclear if the Comprehensive Accountability Report (CAR) was reviewed with staff after review of meeting minutes.

The program has several opportunities to minimize staff turnover and build staff morale. The program gives out different awards to staff such as staff of the month and Tender Love Care winners. In addition, the morale committee has had activities such as recognizing birthdays, jeans on Friday, game nights, and meet and greets. The meet and greets help minimize staff turnover, which is when staff who have been with the program longer meet with newly hired staff to build positive relationships.

The facility administrator (FA) reported the overtime and full-time employee (FTE) reports are reviewed in order to watch the turnover rate. The facility has a morale committee to assist with improving staff morale. The FA reported the program uses several different reports for program planning and assessment purposes. The CAR report is used in all staff meetings when discussing recidivism rates and length of stay. The seven interviewed staff reported having an all staff meeting monthly. During the meetings, there is communication about alerts, youth behavior, schedules, behavior management system, security concerns and trainings. All seven staff reported being told about CAR reports, annual compliance reports and youth/parent surveys. Two of the seven staff reported communication with staff is very good; three said good; one reported fair, and one stated poor. One staff who reported poor stated information sometimes does not get communicated to all staff.

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 for the process of evaluating staff performance. Each position has a job description which clearly states the staff members performance. All seven in-service staff records reviewed had a completed annual evaluation which includes performance standards. After review of the position description and evaluations match for each staff.

The facilitator administrator reported each year staff receive an annual evaluation and is completed by the assistant facility administrator and unit managers and then reviewed with the staff. Two of the seven staff reported receiving yearly evaluation, two reported every six months and the remaining staff reported quarterly.

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 for the process of notifying a youth's parent/guardian and committing court upon admission to the program. Seven youth records were reviewed to determine if the parents/guardians were notified within twenty-four hours of admission. The youth records documented all initial contacts were made within twenty-four hours of admission to the parent/guardians. Each record documented notifications were made, in writing, within forty-eight hours of admission, to the youth's committing court, the juvenile probation officer (JPO), and post-residential services.

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

The program has a policy and procedures for the process for youth to receive orientation upon admission. Seven youth case management records were reviewed for documentation of youth orientation. Each record documented orientation was completed on each youth's date of admission. All of the records contained a detailed checklist of topics which included all required elements. All reviewed records contained acknowledgment forms signed by the youth, verifying they received a copy of the youth handbook, reviewed grievance and emergency procedures, the physical design of the facility, including assignment to living unit and room. The orientation checklist contains all of the required elements and each youth signed statement receiving the youth handbook. All seven interviewed youth confirmed their orientation began within twenty-four hours of their admission.

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

Seven youth case management records were reviewed for the written consent of youth eighteen years or older. Three of the seven youth records were applicable for youth who were eighteen years old or older. Each of the three applicable records had a signed written consent. All forms were signed on the day of admission, as each of the youth was eighteen years of age when admitted to the program.

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

The program has a policy and procedures outlining the requirements for youth assessments and the program's classification system. The program has an internal alert system which is only accessible to staff. All alerts are located on the alert board in the briefing room and are discussed during each briefing at the beginning and ending of each shift.

In each of the seven records reviewed, the admission classification form documented the required initial classification factors, with minor exceptions. Two classification forms were missing documentation of one classification factor each, of which the program indicated was left blank in error. All seven youth were assigned to a room based of the results of the classification process. Each of the seven youth records reviewed were applicable for reassessments. Six records contained reassessments for each youth to determine the youth's ability to participate in work projects involving the use of tools, documented the reason for the reassessment, and if it was approved or not. One youth record contained an initial assessment completed on January 22, 2019, which was completed upon admission. A follow-up assessment was required to be completed thirty days later; however, was not completed until May 1, 2019, during the annual compliance review. The facility administrator was interviewed and indicated the classification meeting takes place during the intake process and during this time, the housing assignment is determined based off the classification factors.

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.	

Five of the seven reviewed records were applicable for youth with gang affiliation. All five of the applicable youth records documented the local sheriff's office, juvenile probation officer (JPO), and the principal of education at the program were notified by written notice of the youth's gang identification. Each of the five youth were previously identified as gang members or suspected gang members prior to the youth's arrival to the program. None of the reviewed records were applicable for post-residential counselor notification.

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.	

Five of the seven reviewed youth records were applicable for youth with gang affiliation. Each of the applicable records documented the youth were attending gang intervention group sessions on a monthly basis, with the exception of one youth. One youth did not participate in the session held the month following admission; however, he did start the sessions and has been actively participating. Each of the five youth were participating in this curriculum on a monthly basis and this was validated by group sign-in sheets. The program utilizes Impact of Crime and A New Freedom curriculum as their gang prevention strategy. The program's director of case management is the gang prevention specialist for the program and is involved in the development of each youth's performance plan. Three of the five youth performance plans included a relevant goal relating to gang intervention strategies. Two performance plans did not include the goal; however, the goal was added the week prior to the annual compliance review. Both youth were actively participating in the gang prevention and strategies since admission. The program utilizes A New Freedom curriculum which incorporates gang intervention topics such as choices and changes, gang intervention, returning home, and getting away from the gang.

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

In each of the seven records reviewed, the Residential Positive Achievement Change Tool (R-PACT) was completed within thirty days of admission and was maintained in the youth's record and the Department's Juvenile Justice Information System (JJIS). The R-PACT Re-assessments were completed within ninety days of the initial R-PACT in each of the seven youth records.

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

In each of the seven reviewed records, a Youth Needs Assessment Summary (YNAS) was completed within thirty days of each youth's admission to the program. Each Youth Need Assessment (YNAS) was documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures for the process of the development of performance plan development, goals, and transmittal. Seven youth records were reviewed for individual performance plan (IPP) development, goals, and transmittal. All of the IPPs were completed within thirty days of admission and each were completed prior to the completion of the Youth Needs Assessment Summary. All of the required treatment team members were present for the development of the IPP and all members signed and dated each IPP. All of the IPPs contained each of the required elements, with the exception of two youth. Two IPPs did not contain an individualized gang-related goal. Each of the youth's IPPs documented the responsibility of the youth and staff, along with their signatures and documented transition goals for each youth. Each of the seven IPPs documented each youth's top three criminogenic goals. A transmittal letter and a copy of the IPP was sent to each youth's juvenile probation officer, parent/guardian, and committing court within ten days. Each of the seven interviewed youth indicated they participated in treatment team meetings once a month, and in informal treatment team meetings every two weeks. Each youth indicated they participated in the development of their IPP, have a copy of their IPP and are working on goals on their IPP, with the exception of one youth who indicated he could not remember if he has a copy of his IPP.

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 of the seven reviewed youth records were applicable for performance plan revisions. Four performance plans were revised due to the Residential Positive Achievement Change Tool (R-PACT) Reassessment results. One youth's performance plan was not revised upon the youth's R-PACT results and did not include the youth's revised top three criminogenic goals; therefore, was revised upon the program becoming aware of the oversight. None of the performance plans were applicable for revisions for transition of the last sixty days of the youth's admission.

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

The program has a policy and procedures in regard to the completion of performance summaries and transmittals. Four of the seven reviewed youth records were applicable for performance summaries and transmittals. Each of the four youth had a ninety-day performance plan update within ninety days of the signing of the initial performance plan. Each of the four applicable performance summaries were completed and contained the required elements. All of the original summaries were found in the youth's case management record. Each of the summaries were signed and dated by the treatment team leader, staff member preparing the summaries, facility administrator, and youth. The committing courts, assigned juvenile probation officer (JPO), and parents/guardians were sent a copy of the performance summaries within ten days of completion. It was unable to be determined if the youth were provided a copy of their performance summaries, nor was it able to be determined if the youth were able to review and comment on the performance summaries. None of the youth were applicable for a release summary or for Department of Children and Families transmittals. Seven youth were interviewed and two youth indicated they were provided with a copy of their performance summary, one indicated they did not receive a copy, and four indicated they were not sure if they received one.

Three closed records were reviewed and each record contained documentation indicating the original release summary and the pre-release notification (PRN) were sent to the assigned JPOs forty-five days prior to each youth's planned release. Each record contained a signed copy of the release summary and approved PRN, with the exception of one. One youth record did not contain an approved PRN from the court, as the judge for this youth does not sign PRNs. There was an email in the youth's record from the JPO acknowledging the youth's release. There was documentation in each youth record showing the program notified the youth's parent/guardian of each youth's release and each contained an Exit Residential Positive Achievement Change Tool (R-PACT). None were applicable for sexually violent predator program.

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

A review of the seven youth records and three closed records documented parent/guardian involvement throughout the youth's progress in the program to include, but not limited to, the intake/assessment process, performance plan development, and participation in treatment team and transition meetings either in person or by phone. Seven youth were interviewed and each indicted their parent/guardian participated in each of their treatment team meetings, visitation, family days, and family counseling sessions. Each youth indicated they are able to

communicate with their parent/guardian by telephone and letter writing. Three treatment team meetings were observed where parents/guardians were contacted at the start of each treatment team meeting. The facility administrator indicated each parent/guardian is contacted during the intake process to participate and each are mailed a copy of the program's parent handbook. He also indicated each parent/guardian is contacted during treatment team in order to participate. A review of the program's contract validated the performance measures have been met.

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 assigning members of treatment teams. The program identifies a leader for each intervention and treatment team. At a minimum, the treatment teams are comprised of a treatment team leader, the youth, an administrative representative, living unit representative, treatment staff, educational staff, juvenile probation officer (JPO), parent/guardian, nurse, recreation therapist, and gang prevention specialist, if applicable. A review of seven youth records documented each of the identified treatment team members participated in each youth's formal treatment teams; the parent/guardian and JPO were contacted for each treatment team meeting and participated by phone, if available. There were no applicable youth receiving services from the Department of Children and Families nor the Agency for Persons with Disabilities.

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

The program has a policy and procedures to address the incorporation of other plans in the youth's performance plans. A review of seven youth records, validated all seven youth's performance plans incorporated each youth's academic and treatment plans. None of the youth were applicable for a case plan through the Department of Children and Families nor through the Agency for Persons with Disabilities.

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

The program has a policy and procedures to ensure the intervention and treatment team meets every thirty days and reviews the youth's performance. A review of seven youth records validated each treatment team meeting for the seven youth included the youth, the youth's juvenile probation officer (JPO), representative from administration, living unit representative,

and the youth's parent/guardian, with education submitting written documentation for each meeting. None of the youth treatment team meetings were missed for any of the seven youth. The program conducts bi-weekly informal treatment team meetings and of the seven youth records reviewed, all documented an informal treatment team meeting was held each month with the exception of one youth. For this one youth, one informal meeting was missed out of one. Each treatment team review, both formal and informal, documented information such as the date of the review, comments from the treatment team, a summary of the youth's progress, performance plan revisions, goal progress, positive and negative behaviors, physical interventions, treatment progress, and Residential Positive Achievement Change Tool (RPACT) results. Each youth was provided an opportunity to demonstrate skills and to make comments. A review of treatment team documentation for each youth validated all required documentation was present.

Three treatment team meetings were observed during the annual compliance review. In the three meetings, the youth, clinical director, school principal, living unit representative, transitional case manager and medical staff were present for each. The JPO and parent/guardian were contacted for each meeting and participated, if available. The director of case management and case manager participated in two of the three meetings. Each youth record documented the Department's Juvenile Justice Information System was updated every ninety days with each youth's anticipated release date. Seven youth were interviewed, and each indicated they have an opportunity during treatment team meetings to demonstrate the skills they have learned while in the program.

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

The program offers is a Type 3, career education programming. The Osceola County School District provides the career education programming which is appropriate based upon age, assessed educational abilities, and goals of the youth in the program. The program utilizes My Florida Ready to Work, My CareerShines, and Kuder Skills Confidence assessments, to assess the youth's personal accountability skills. The program works closely with the education agency, to ensure youth are receiving the training on personal accountability skills and behaviors leading to appropriate work habits for employment and living standards. The youth case records documented both the school district and the program includes communication, interpersonal, decision-making skills, and employability skills during the career education training.

Three closed youth case management records were reviewed. Each of the records included documents essential to obtaining employment, sample completed employment applications, a resume, and a calendar to identify an appointment with Career Source Center. The documents were signed by the youth's parent/guardian, juvenile probation officer (JPO), and program representative.

An interview was conducted with the facility administrator, who stated the staff and school administration are currently working to implement an agriculture class and a culinary arts curriculum through the support of the Osceola County School District. An interview was conducted with the principal, who is employed by the of Osceola County School District, who stated, the vocational class curriculum will become embedded in a digital computer class during the next school year. The youth career education folders and portfolios are kept in a classroom file cabinet, which is inaccessible to youth.

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 Osceola County School District operates year-round education and vocational programs. Educational services include the development of individualized educational plans, progress monitoring plans, and individualized academic plans for each youth, in addition to classroom instruction. The program operates on a schedule approved by the Osceola County School District, which includes ten days of teacher planning and training. The program schedule, logbooks, and observations verified youth received 300 days of instruction distributed over twelve months; including a minimum of twenty-five hours of instruction weekly with minimal interference.

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

Three closed youth records were reviewed for education transition plans. Each record included appropriate documents essential for the youth to obtain employment upon leaving the program. Evidence supported services, based on the youth's assessed educational needs, were rendered to each youth during their program stay. Each youth received employability training experience, which included completing an employment application and a resume, a valid State of Florida identification card, birth certificate, social security card, school transcripts, and a calendar with a follow-up appointment with the Career Source Center. The implementation of these services provided for the continuation of education and/or employment. A certified school counselor was at the program and a school district designee who has access to the district's Management Information System, to receive educational records. Evidence reviewed in the youth case records indicated the youth's case manager, juvenile probation officer (JPO), and parent/guardian, and were aware of the plan, documents, and post-release discharge plans.

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 records were reviewed, and each documented the Transition Conference was held at least sixty days prior to each youth's anticipated release date. The youth, treatment team leader (case manager), facility administrator, transition specialist, clinical director, and therapist attended the Transition Conferences for each youth. In addition, the juvenile probation officer (JPO) and parent/guardian participated by phone, and educational and medical staff provided written documentation for each transition conference. The JPO, parent/guardian, and educational staff were all sent written notification of the Transition Conference for each of the three youth. During each Transition Conference, the participants reviewed the youth's performance goals and revised them, if necessary, identified additional goals, if needed, identified target completion dates and persons responsible for completion of each. Each attendee signed and dated the Transition Conference Plan. Each of the three transition plans were mailed to the JPO. Each youth and parent/guardian attended the Community Re-Entry Team (CRT) meeting, which was conducted prior to each youth's release. Each youth's case manager was invited by an email invite for the CRT.

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

Three closed youth case records were reviewed and each included an exit portfolio with, evidence the exit portfolio was discussed during the transition conference. Each exit portfolio contained a state-issued identification card, social security card, a copy of the youth's transition plan, calendar noting dates and times of follow-up appointments in the community, birth certificate, vocational certificates earned in the program, education records, résumé, and completed job applications. It is noted and mentioned during the exit conference, the education staff will forward the exit portfolio information to the receiving school district. All three exit portfolios were verified at the exit conference and completed upon release. The program staff signed and dated the document as to when the exit portfolio information will be forwarded to the juvenile probation officer (JPO) and is documented in each of the three youth case management records.

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 youth closed records were reviewed and each youth participated in an Exit Conference. Each juvenile probation officer (JPO) was notified of the Exit Conference date prior to the meeting. Each of the three Exit Conferences were held at least fourteen days prior to the youth's release. Each Exit Conference form documented the date, signatures of participants, and a summary of the youth's transition goals. Each of the three youth's admission and termination dates were compared to the dates in the Department's Juvenile Justice Information System and each matched. The intervention and treatment team leader, parent/guardian, education representative, JPO, youth, medical staff and clinical director participated in each of the three Exit Conferences. The Exit Conferences, Transition Conferences, and Community Re-entry Team meetings were separate for each of the three youth.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a written policy and procedures indicating the clinical coordinator is to be on-site, a minimum of, forty hours a week for the coordination and implementation of mental health and substance abuse services in the program. The designated mental health clinician authority (DMHCA) is an employee of the program and is a licensed clinical social worker (LCSW) and also serves as the clinical director. The clinical director is responsible for coordinating and verifying implementation of mental health and substance abuse services. The clinical director job description outlined duties as the designated mental health clinician authority. As a part of the assigned responsibilities, the clinical director shall ensure consistent and appropriate mental health and substance abuse services and shall be available on-call twenty-four hours a day, seven days a week to provide consultation in the event of emergencies. The clinical director is licensed under Chapter 458 and 459, with a license expiring March 31, 2021.

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

The program has a policy and procedures for ensuring mental health and substance abuse services are provided by individuals with appropriate licensure. The designated mental health clinician authority (DMHCA) is an employee of the program and is a licensed clinical social worker (LCSW) with the title of clinical director. A review of the DMHCA's license indicated the license has an expiration date of 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 four master's-level, non-licensed staff providing services to the youth. All non-licensed clinical staff work under the direct supervision of the designated mental health clinician authority (DMHCA). A review of the clinical supervision log found each non-licensed staff

received at least one hour of face-to-face direct supervision from the DMHCA each week. The clinical supervision log and the form used to document the direct supervision includes all required information. The supervision log maintained weekly clinical supervision meeting minutes and agendas. Each of the non-licensed staff received twenty hours of Assessment Suicide Risk training.

The meeting documentation supported clinical case consultation, individual treatment issues and youth-specific focus were addressed during weekly supervision meetings. The program maintains a current Chapter 397 license through the Department of Children and Families to provide substance abuse services for outpatient treatment. The non-licensed clinical staff provide substance abuse education under the direct supervision of the licensed DMHCA. These services are offered during the youth's individual sessions.

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.	

Seven open mental health and substance abuse youth records were reviewed for documentation of a comprehensive screening process ensuring a referral was made when youth have an identified mental health and/or substance need. All seven records indicated the Massachusetts Youth Screening Instrument Second Version (MAYSI-2) was completed in the Department's Juvenile Justice Information System (JJIS) by a trained staff the day of admission. Each record contained documentation confirming the case manager and therapist reviewed each youth's commitment packet information, reports and records for existing documentation of identified mental health and substance abuse needs, and relevant mental and behavioral health history needs or risk factors relevant to mental health and/or substance abuse concerns. The review was documented on the Commitment Packet Review Checklist and circulated to the facility director, clinical director, education coordinator, and nurse for review prior to, or on the day of the youth's admission. When the MAYSI-2 or Clinical Mental Health and Substance Abuse Screening indicates the need for further in-depth mental health or substance abuse evaluation, the youth shall be referred for a Comprehensive Mental Health Evaluation or Comprehensive Substance Abuse Evaluation and all seven records met the requirement. All five applicable youth were placed on precautionary observation and referred for an Assessment of Suicide Risk (ASR) based on the intake screening documents. All five records contained an ASR which was completed the day of admission by a therapist and signed off by the clinical director. All five youth were removed from precautionary observation by the clinical director following the results of the ASR and notifications were made to the facility administrator. Suicide risk alerts were entered into JJIS, as required. All seven reviewed youth records contained a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment. All seven youth records contained a Brief Behavioral Health Evaluation completed by the clinical director or a therapist, regardless of the results of the MAYSI-2. All seven youth records contained a completed American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance Related Disorders (Admission ASAM) the day of admission.

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 indicating all youth will receive a Youth Outcomes Survey (YOQ) to assess clinically significant mental health and substance abuse needs/risks. The YOQ found in all seven youth records reviewed is a measure of treatment progress for youth receiving mental health interventions and is meant to track actual change in functioning. The Social Skills Improvement System (SSIS) completed by the case manager, assess social skills and problem behavior needs/risks. The SSIS is completed within twenty-one days of the youth's admission to the program and prior to the youth's release. A SSIS was found in all seven records reviewed. All youth received a comprehensive mental health evaluation and/or comprehensive substance abuse evaluation within thirty days of referral. None of the youth received an updated assessment. All seven youth were identified by screening, staff observation, or behavior after admission, and in need of further evaluation were referred for a comprehensive mental health evaluation and comprehensive substance abuse evaluation. The program has combined the comprehensive mental health evaluation and comprehensive substance abuse evaluation into one document which captures the required information. All seven records had a comprehensive evaluation completed within thirty days of admission. No updates were noted during the review due to all youth receiving a new assessment.

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

A total of seven mental health and substance abuse (MH/SA) youth records were reviewed for MH/SA treatment. All seven youth were assigned, at admission, to a multidisciplinary treatment team which included the youth, the youth's parent/guardian, clinical director, representative from case management, and program operations staff, as well as medical. The treatment team is responsible for developing, reviewing, and updating the youth's individualized MH/SA treatment plan and discharge treatment planning. All seven records included a signed Substance Abuse Consent and Release forms. All seven records included a MH/SA initial treatment plan implemented the day of admission and had an individualized mental health and substance abuse treatment plan completed within thirty days of admission. Six of the seven youth records reviewed were applicable for MH/SA services as a result of the comprehensive evaluation. All seven MH/SA youth records had a current Authority for Evaluation and Treatment form (AET). Youth can receive specific clinical interventions and treatment methods such as individual, group, and family therapy, behavioral therapy, psychoeducational training, medical/psychiatric services and individual substance abuse treatment. Six of the seven youth were receiving individual, group, and family therapy, as well as behavioral therapy. All seven youth had mental health treatment notes or substance abuse treatment notes documenting the counseling/therapy the youth received. The program documented their notes on a form containing all the

information required. All seven interviewed staff reported only therapist facilitate mental health and substance abuse groups.

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

A total of seven mental health and substance abuse (MH/SA) youth records were reviewed for treatment and discharge planning. All seven MH/SA records contained an initial treatment plan completed the day of admission. These plans were signed by the treatment team and clinical director. These plans document when mental health services are to begin and the initial course of treatment. The initial treatment identified in all reviewed youth records included the reason for referral, initial diagnoses or presenting symptoms, initial treatment methods and initial treatment goals. All seven applicable MH/SA records contained an individualized MH/SA treatment plan which was completed within thirty days of admission. All parties of the youth's treatment team signed and dated the plan and the plans contained all required elements including the youth's diagnosis, a description of specific symptoms, measurable and achievable goals and a list of services. Each service had the amount, frequency, and duration for each. All plans were approved by the licensed mental health counselor.

Two youth were admitted with psychotropic medications and the initial treatment plan and individual treatment plan addressed the service, and documented the frequency for monitoring by the psychiatrist included in the plan. All seven youth were seen by the psychiatrist within the youth's first thirty days and had an initial diagnostic interview completed. Four youth were prescribed or continued on medications and had an explanation for the needs for the medication.

All seven youth records had a monthly treatment team review which addressed the youth's progress or lack of progress toward meeting each of the identified treatment goals; identified any unmet needs and address how these needs will be met; reviewed the youth's continued need for services and the appropriateness of the current level of care and services; made any modifications, including addition of new goals to the plan which is needed to improve the delivery of services to the youth and parent/guardian; reviewed any significant behaviors and changes needed in the plan; reviewed any new or previously unknown information which impacts the treatment of youth and impedes projected discharge date and/or planning.

Three closed records were reviewed for the discharge summary and all records contained a discharge summary with documentation indicating the discharge plan was discussed during the youth's exit conference. None of the youth were released on suicide risk or precautions, requiring a notification to the parent/guardian and juvenile probation officer (JPO). Documentation noted each youth, parent/guardian, and JPO received a copy of the discharge summary. An exception noted during the annual compliance review found a youth whose

individualized plan indicated the youth will receive individual and family counseling once a month. Progress notes did not indicate youth received individual counseling in December. Progress notes and parent/guardian contact log did not document family counseling.

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.".	

A review of the program's contract and clinical program description indicated services are available through the provision of mental health overlay services (MHOS) and borderline developmental disability/developmental disability services (BDD/DD). Each youth is assessed upon admission for mental health and substance abuse needs utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), the Department's Assessment of Suicide Risk (ASR), the Adolescent Substance Abuse Subtle Screening Inventory (SASSI-2), Beck Depression Inventory, the Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment, a confidence assessment, and initial records review. The program's specialized mental health treatment services include individual therapy sessions, monthly family therapy sessions, and mental health treatment groups which are provided seven days a week. Supportive counseling is provided on an as-needed basis. For the MHOS unit, the program maintains a ratio of one-to-fifteen on the clinician caseloads. For the BDD/DD unit, the program maintains a ratio of one-to-ten on the clinician caseloads. The program provides youth-appropriate developmental therapeutic activities seven days a week and contracts with a behavior analyst to conduct behavioral assessments on youth with higher needs. Each time the behavior analyst meets with the youth, a treatment note, and individualized graphing of youth behaviors are provided to further help the program meet youth needs and address target behaviors. Youth also have access to a psychologist who conducts individual therapy sessions when necessary. The program maintains an independent contractor agreement with a State of Florida board-certified licensed psychiatrist providing on-site services. A review of seven youth mental health records validated each youth received a psychiatric evaluation after the youth's admission to the program. The psychiatrist is on-site weekly for both specialized services as indicated by weekly sign-in and patient logs.

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

The program maintains an agreement with a psychiatrist practicing child and adolescent psychiatry. The reviewed license showed the program's psychiatrist carries a medical doctor (MD) license. The program does not utilize an advanced registered nurse practitioner (ARNP). A review of the psychiatric visitor log confirmed the psychiatrist has been on-site at least once a week during the annual compliance review period and is available for emergencies and consultation twenty-four hours a day, seven days a week. The program's psychiatric services include psychiatric evaluations, psychiatric consultation, medication management, and medical supportive counseling. Seven youth records were reviewed, and four records showed youth were prescribed or continued on psychotropic medications while attending the program. The program practice is to refer all youth for an initial psychiatric evaluation, regardless of

medication status. Seven reviewed records showed a psychiatric initial diagnostic interview completed within thirty-days of admission. Each diagnostic interview documented youth history, mental status examination, Diagnostic and Statistical Manual, Fifth Edition (DSM-5) diagnosis, treatment recommendations, applicable prescribed medications, explanation of medications, and frequency of medication monitoring. All reviewed records documented the initial diagnostic psychiatric interview on the Clinical Psychotropic Progress Note (CPPN). Each contained page three of the CPPN, clearly documenting a treatment plan discussion with youth and parent/guardian. Each youth prescribed psychotropic medications received medication reviews at least every thirty days. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the program's psychiatrist supported weekly on-site visits. The psychiatrist reported the role of providing initial psychiatric evaluations for every youth entering the program, providing medication management for all youth on psychotropic medications.

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

The program has a written plan detailing the suicide prevention procedures in accordance with Rule 63N-1, Florida Administrative Code. The plan includes the following: identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral process and, self-referrals, documentation, immediate staff response, review process and, safe housing. The levels of supervision being used are one-to-one supervision, constant supervision and close supervision. The plan was signed and approved by the facility director and clinical director.

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

The program maintains a written comprehensive suicide prevention plan to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The program maintains a suicide response kit located in the master control area. Observations during the annual compliance review confirmed each kit contained the knife-for-life, wire cutters, and needle nose pliers.

A review of seven youth mental health records found each youth was screened upon admission utilizing the Department's Assessment of Suicide Risk (ASR) to determine if the youth had elevated suicide risk factors. Six of the seven ASRs determined the youth were not at risk of suicide and were placed on standard supervision. The one youth was subsequently placed on

precautionary observation based on the ASR. Two other youth were placed on precautionary observation after staff observed the youth's behavior. The ASRs supported these youth should be maintained on precautionary observation. While on precautionary observation, program staff maintained Suicide Precautions Observation Logs. Follow-up ASRs were completed for each youth prior to the removal of precautionary observation. The licensed therapist and the facility administrator documented their communication prior to stepping down the youth's level of supervision. The program's logbooks contained documentation of when youth are placed on precautionary observation and when they are stepped down to less restrictive supervision.

Youth placed on an elevated level of supervision due to suicide risk had an alert placed in the program's internal alert system, program logbook, and the Department's Juvenile Justice Information System (JJIS). Alerts were subsequently removed when the alert was no longer warranted. Training records for the one non-licensed staff who completed ASRs validated the staff completed the required twenty-hours of training which included the administration of five assessments of suicide risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional. The program has a policy indicating the program does not use secure observation. All seven staff reported when a youth expresses suicidal thoughts, direct care staff are responsible for notifying mental health and placing the youth on precautionary observation with constant sight and sound supervision. All three interviewed youth who were placed on precautionary observation indicated staff never left the youth for any period of time while the youth were on precautionary observation.

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.	

A review of seven youth mental health records found three were applicable for precautionary observation (PO). The reviewed logs were maintained for the duration the youth was on suicide precautions. The logs documented the safe housing areas of the program and the level of supervision and observations of the youth's behavior were documented in real time. Each shift supervisor and mental health staff signed the logs daily.

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

A review of fourteen training records for direct care and supervisory staff supported each staff received at least six hours of annual training in suicide prevention and implementation of suicide precautions. The program includes suicide prevention training in both the pre-service and in-service training plans. Training was conducted face-to-face by the program's staff, as well as online in the Department's Learning Management System (SkillPro). A review of the program's suicide drills for the last four quarters found the drills were conducted quarterly; however, when reviewing documentation to ensure mock drills were on every shift, the drill documentation reflected the activity at the time of the drill was during staff meetings. Other drill documentation had second and third shift staff sign-in sheets but no delineation of a separate drill being conducted on the coinciding shifts or a critique for each drill. After review of all the drills, it could not be verified if these were actual mock drills.

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

The program has a written crisis intervention plan. The plan addresses procedures to respond to youth in crisis in the least restrictive method possible. The plan detailed crisis intervention procedures to include notification and alert system, means of referrals, including youth self-referral, communication, supervision, documentation, and review process. The program's plan was reviewed, approved, signed, and dated by the designated mental health clinician authority and facility administrator on the revised date of August 1, 2018.

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.	

Seven youth mental health records were reviewed and found none were applicable for crisis assessments. An interview with the designated mental health clinician authority (DMHCA) indicated there were no applicable youth who required a crisis assessment during the annual compliance review period. The program has a process in place to ensure when a youth is in crisis, the program utilizes a crisis assessment which addresses all required information and would be completed by the clinical staff.

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

The program has a written emergency plan which was last revised and approved by the designated mental health clinician authority (DMHCA) and facility administrator on August 1, 2018. The emergency plan addressed procedures for emergency identification and immediate staff response, supervision, authorization of transport for emergency services and transportation for mental health and substance abuse emergencies, documentation, review, and staff training. The plan identified a local emergency mental health evaluation, Marchman act and treatment center for youth in need of emergency services. All seven interviewed staff stated they would call 9-1-1 and have access to rescue tools in case of an emergency.

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.	

None of the seven records reviewed were applicable for a Baker Act or Marchman Act. Three additional youth records were provided by the program for review. Two of the youth were referred by the mental health professional and one was Baker Acted by a county sheriff. One of the two youth referred by the mental health professional threatened to harm himself during the admission process. He was placed on supervision at this time. His level of supervision was one-to-one while receiving Baker Act services off-site. A review of the supervision logs indicated the required checks were made and the youth never left sight or sound of the mental health staff. The second example reviewed was a youth who attempted self-harm while in the program. This youth was immediately placed on one-to-one supervision by the mental health staff while being Baker Acted. A review of the supervision logs indicated all required checks were made and the youth never left sight and sound of the mental health staff. The third example was a youth who threatened to harm himself following an abuse call where he became upset, started acting out, and threatened to harm himself and others around him. The facility administrator called the Sheriff's Office who Baker Acted the youth after their arrival. The youth was not placed on any level of supervision but never left the sight and sound supervision on the facility administrator, shift supervisor, or sheriff. All three youth were placed on constant supervision by mental health staff after returning to the program. All three youth received a referral upon their return to the program for a Mental Status Exam. The youth received an Assessment of Suicide Risk (ASR) by the licensed mental health counselor (LMHC) and maintained on constant supervision and transition down to a lower level of supervision following completion of follow-up ASR every 24-hours. A review of supervision logs indicated all three youth were supervised accordingly. Documentation indicated the LMHC communicated with the facility administrator at every stage of the youth's transition through the levels of supervision. There were no Marchman Acts during the annual compliance review period.

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's written facility operating policy and procedures (FOP) states the program will identify a designated health authority (DHA) to be responsible for the overall clinical direction of the program, as well as the medical nursing protocols and medical FOP, and to make final clinical decisions regarding the provision of healthcare.

The program contracts with a medical doctor (MD), who is board certified in internal medicine, to serve as the program's DHA. The DHA is a physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida. The DHA has a collaborative agreement with a physician assistant (PA) who will provide coverage when the DHA is unavailable. The program's contract specifies the DHA to be on-site at least two hours per week. The DHA was on-site at least once a week for a minimum of two hours in the last six months indicated by the review of the sign-in logs. The DHA communicates with program staff at least weekly regarding medical needs, and is available twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The medical staff have active and current licenses in the State of Florida, the PA's expiring on January 31, 2020, and the two registered nurses (RN) expiring on April 30, 2021.

The interview with the DHA indicated he is on-site weekly and on-call twenty-four hours a day, seven days a week. He sees youth to complete Comprehensive Physical Assessments (CPA), periodic evaluations, conducts sick call follow-up, if needed, reviews off-site visits, and is included in policy and procedures development, as well as meeting weekly with the health services administrator to discuss youth health issues and status.

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

The program has written facility operating policies (FOP), procedures, and protocols outlining the program's health care services. The nursing staff signed a cover page acknowledging the review of all FOPs, treatment protocols, and procedures. The approval of treatment protocols was authorized by the designated health authority (DHA) who dated and signed them. The DHA and psychiatrist signed their respective written FOPs, but there were no signatures to determine when this occurred. A cover page was signed and dated by the DHA, the facility administrator, and the nursing staff acknowledging an annual review of all FOPs and protocols had occurred. The program's FOP related to psychiatric services and psychotropic medication management have been reviewed by the designated mental health clinician authority (DMHCA); it was signed but not dated. The program has one new registered nurse (RN) who received a comprehensive clinical orientation upon hire.

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.	

In all seven records reviewed, either an original Authority for Evaluation and Treatment (AET) or a copy of the AET with the word "copy" stamped on the document was observed. One of the seven youth turned eighteen years old while in the program and an AET for youth over the age of eighteen was found in the Individual Healthcare Record (IHCR). In all of the records, the AET is valid for as long as the youth is under any type of supervision, custody, or other form of legal control by the Department, or for one year after it was signed by the parent/guardian, whichever comes later. The AET is valid until the youth's eighteenth birthday. In all records, copies of parental notifications were maintained behind the AET in the IHCRs.

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

The program has written facility operating procedures (FOP) which address parental notification. In all seven records reviewed, parental notifications included new medication and off-site visits. Verbal attempts were documented in the progress notes, as well as written notifications, which were sent regardless of telephone notifications. Documentation reviewed confirmed a staff member witnessed all telephone call attempts and conversations.

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

Two of the seven youth records reviewed were applicable for parental notification regarding consent for new, discontinued, or adjustments of psychotropic medications. One additional record was reviewed. In the three applicable records reviewed, when a psychotropic medication was initially prescribed, or significant changes occurred, parent/guardian notification and consent was obtained. Notifications were mailed along with the Clinical Psychotropic Progress Note (CPPN) for the initiation of psychotropic medication and a verbal consent was obtained. The CPPN documented a staff member witnessed all consent phone calls and conversations.

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

In all seven records reviewed, youth vaccinations were verified within thirty days of admission. None of the records had a refusal of consent. The nurses review the immunization status at the time of admission and when needed. Immunizations are provided by the Osceola Health Department after receiving consent.

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

In all seven records reviewed, the Facility Entry Physical Health Screening (FEPHS) form was completed on the day of admission by the registered nurse (RN).

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

The program has a medical alert system. In all seven records reviewed, the program's internal alert system matched alerts entered into the Department's Juvenile Justice Information System (JJIS), as well as the alerts identified in the Individual Healthcare Records (IHCR). Two youth were med grade 5, two med grade 3, two med grade 1, and one med grade 2. The nursing staff verified all alerts were up-to-date. Three youth were identified with a chronic condition.

Seven staff were interviewed regarding how youth medical alerts are shared with staff. One of the seven stated alerts are printed when youth arrive at the program, six said during the shift briefing, one mentioned administration informs the case manager, four said alerts are shared on the alert board in the conference room, one stated in an email, and one indicated with the medical alert sheet.

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

The program has written facility operating procedures (FOP) regarding youth orientation to healthcare services. In all seven records reviewed, the youth received a healthcare orientation the day of admission to the program. The healthcare topics included access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process to include side effects monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care providers.

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

The program has written facility operating procedures (FOP) indicating the designated health authority (DHA) shall be notified immediately when an admitted youth requires emergency care. The registered nurse (RN) will notify the DHA of any health conditions requiring review. Notification will be completed by telephone or electronically and documented in the Individual Healthcare Record (IHCR).

In four of the seven records reviewed, the youth did not have a known or suspected chronic condition when admitted. In the other three records, the youth were admitted with a chronic condition. Upon admission the DHA and psychiatrist were notified telephonically.

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

None of the seven records reviewed were applicable for healthcare admission rescreening; therefore, three additional records reviewed. Each of the three applicable youth had a change of physical custody and a new Facility Entry Physical Health Screening (FEPHS) form was completed by the registered nurse (RN) at the time of readmission.

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

Each of the seven reviewed records contained a new Health Related History (HRH) form which was completed within seven days of admission by a registered nurse (RN). The designated health authority (DHA) also reviewed the HRH form which was documented on the Comprehensive Physical Assessment (CPA). The HRH form was completed prior to the CPA in each of the seven records.

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

The program has written facility operating procedures (FOP) stating the youth's medical grade is required to be documented on the Comprehensive Physical Assessment (CPA). Additionally, all fields on the CPA will be completed, as required. If a part of an exam is not conducted or refused by the youth, it will be indicated in writing. For example, if the youth refuses Tanner Stage portion of the exam, the refusal will be noted and should be signed by the youth attesting their refusal. If a discretional portion of an exam is determined not necessary by the clinician, the clinician should indicate "deferred by the clinician." If a refusal of an exam poses a substantial risk to the youth, the parent/guardian, designated health authority (DHA), or designee and the facility administrator will be notified.

In all seven records reviewed, a new CPA was completed within seven days of admission by the DHA with med grades ranging between 1, and 3. The CPAs were completed, as required, sections of the CPA were marked with an "X" and the youth signed the documented refusal. The Department's Problem List was updated in each of the seven records reviewed.

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

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

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

The program has a written facility operating procedure (FOP) regarding tuberculosis screening, which is in compliance with the Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) Occupational Safety and Health Standards.
In all seven records reviewed, the Individual Healthcare Record (IHCR) documented a Tuberculin Skin Test (TST) within the last year and the results were documented on the Comprehensive Physical Assessment (CPA) and Infectious Communicable Disease (ICD) forms.

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

All seven records reviewed documented the youth were screened and evaluated for Sexually Transmitted Infections (STI), testing was performed and the results were documented on the Infectious and Communicable Disease (ICD) form, as well as the lab results filed in the lab section of the Individual Healthcare Record (IHCR). The program utilizes standing orders wherein youth are screened when they meet certain criteria.

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

In all seven records reviewed, the youth were offered Human Immunodeficiency Virus (HIV) counseling. Four of the seven youth consented to testing, which was completed. All of the tests results were filed in a confidential manner in a sealed envelope marked “CONFIDENTIAL.” All four records in the Individual Health Education Record documented the pre and post-test counseling completed by a provider on-site. The HIV counselor is certified in providing counseling and testing services. The program’s internal alert system did not document HIV status.

All seven youth interviews indicated they can request HIV testing.

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

The program has written facility operating procedures and policy (FOP) indicating when a licensed nurse is not on-site, the shift supervisor reviews all sick call requests within two hours of the request being submitted. Any complaints of severe pain shall be treated as an emergency and the licensed heath care professional shall be notified. The program's contract indicates sick call is to be provided, a minimum of, once a day, seven days a week. Sick call shall only be conducted by a registered nurse (RN) or when there is no nursing staff on-site, the shift supervisor must review sick call requests within two hours and contact the designated health authority (DHA) if determined urgent. The program's sick call hours are Monday through Friday 8:00 a.m. to 2:45 p.m. and Saturday and Sunday at 8 a.m. Sick call forms were located on each module and accessible to youth to complete and place in the sick call box.

None of the youth in the seven reviewed records presented with three or more similar sick call complaints within a two-week period or of any severe pain with which staff was unfamiliar with. In five of the seven records, the completed sick call request forms were filed with the progress notes in the Individual Healthcare Record (IHCR) in reverse chronological order. In the other two records the youth did not have a sick call.

The program staff indicated they do not use a computerized sick call system.

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

In five of seven records reviewed, the youth were seen by the registered nurse (RN) and the sick call forms were documented in accordance with the Health Service Rule and on the Sick Call Index. The youth signed the sick call form and it was filed within the Individual Healthcare Record (IHCR) in reverse chronological order. In the remaining other two records, the youth did not request a sick call.

The program keeps sick call forms on each dorm and they are accessible to youth. A sick call was observed during the annual compliance review with the verbal consent of the youth. The youth was escorted to the clinic by a direct care staff who remained outside of the door of the exam room during the visit. The youth's exam was completed in a private area with no other youth present to hear or see the examination. The RN introduced herself and stated why the youth requested the sick call and asked the youth what his symptoms were. The exam table and several different instruments were utilized to conduct the assessment by the RN. The youth signed the sick call form after being seen and receiving an explanation of treatment.

All seven staff interviews stated the nurse conducts sick call.

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

The program has written facility operating procedures and policy (FOP) which states 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, or when non-physical interventions would not be effective. Controlled observation shall not be used as a form of punishment or discipline. Youth demonstrating acute psychological distress shall not be placed in controlled observation. The facility administrator shall ensure all use of controlled observation is implemented only as authorized and in accordance with policy. All program staff shall be sufficiently trained in both the use and documentation of controlled observation.

Only one of the seven records was applicable for review of controlled observation. Two additional records were reviewed. In the three applicable records reviewed, the youth were in controlled observation and were questioned as required for sick call/health complaints. The nurses made daily visits and documented this in the progress notes in the Individual Healthcare Records (IHCR). None of the three were applicable to receive prescribed medications while in controlled observation. All three youth were informally interviewed and each indicated they were seen by a registered nurse (RN) while in controlled observation but all said they were not in need of medication at the time.

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

The program has written facility operating procedures and policy (FOP) including episodic and emergency care procedures. The policy states twenty-four-hour emergency medical, mental health, substance abuse and dental care shall be available to youth.

One of the seven youth records reviewed was applicable for episodic care; therefore, two additional records were reviewed. Each of the three applicable records had an episodic care event which was documented using narrative charting and included the date/time of care, nature of the complaint, findings of the person rendering care, treatment rendered, and the printed name and credentials of the healthcare staff providing the care. All episodic/first aid events reviewed were located in the episodic care log.

The program has five first aid kits which are monitored on a monthly basis by the registered nurses (RN), as well as replenished when needed. One first aid kit was located in master control East, one in master control West, two for the vehicles in the main master control room, and one other in the kitchen. The four first aid kits located in the master control rooms were reviewed and observed to have all approved content. The East and West master control rooms also have one suicide response kit each; both had wire cutters, pliers, and a knife for life. The program has one automated external defibrillator (AED) which is located in the staff break room.

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

The program has written facility operating procedures and policy (FOP) including episodic and emergency care processes. All seven in-service and seven pre-service training records reviewed, as well as the nursing staff certifications, indicated staff were trained in first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR). The emergency numbers are posted on the wall within the clinic, in the nurses' office, which youth are prohibited from entering. The program has one AED which is located in the staff break room in a box marked "AED." The AED box contains the procedures. The nurse conducted a check on the AED and it was observed to be functioning properly. The AED pads expire March 31, 2020 and the battery pack November 30, 2021. This AED also has a 9-volt battery which is checked every week. The battery pack was changed on May 22, 2018 and the pads April 29, 2019. A review of AED checks indicated they were conducted on a weekly basis since the last annual compliance review. The program has a list of non-healthcare staff which are trained in the administration of the epinephrine autoinjector. A review of the last four quarters of medical drills indicated the program conducted a minimum of one drill once a quarter on each shift, which included the administration of first aid and/or CPR techniques. Staff who have direct contact with youth on a day-to-day basis participated in at least one medical drill in the last year.

All seven interviewed staff indicated they are personally allowed to call 9-1-1 if a youth has a medical emergency.

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

Four of the seven youth records reviewed were applicable for off-site care. Parental notification was made in each of the four applicable records. The summary of off-site care was used and filed in the Individual Healthcare Record (IHCR). The designated health authority (DHA) reviewed and signed all off-site care findings, instructions, and information. Three of the four youth required follow-up care. Two of the three received the follow-up care. In the remaining one record, the parent/guardian had not consented to the follow-up treatment at the time of the annual compliance review.

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

Four of the seven youth records reviewed were for youth identified with a chronic illness. The youth had chronic conditions classified with med grades 2-5, and were placed on a chronic illness list, receiving evaluations at no greater than three months intervals, where enough time had passed, as well as a treatment plan. The periodic evaluations were tracked, the documentation was maintained in the Individual Healthcare Records (IHCR) and orders were written so clinical staff could distinguish them clearly. The evaluations were completed on-site. The Department's Problem List was updated as needed.

The designated health authority (DHA) and nursing staff stated youth with chronic illnesses are placed on the medical alert log to track them. The facility administrator explained he shares pertinent medical information pertaining to the youth in the program with the program staff during daily debriefings, all staff meetings and management meetings.

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

The program has written facility operating policy and procedures (FOP) regarding medication verification. Two of the seven reviewed youth records were applicable for youth entering the program with medication; therefore, one additional record was reviewed. In the three applicable records reviewed, the youth was taking medication at admission which was verified by a nurse prior to being accepted into the program. The program utilized a document for verification of the medication, which was maintained in the youth's Individual Healthcare Record (IHCR) and the designated health authority (DHA) and/or psychiatrist were notified to continue the medications.

The nursing staff indicated staff training includes how the Medication Administration Record (MAR) is to be completed.

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

In all seven records reviewed, the youth had current, valid orders for medications where were given pursuant to a current prescription. When the youth were ordered new/continued medications, the designated health authority placed an order on the practitioner order form. None of the youth received any over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET).

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

All medications are secured in either the locked medication cart located in the clinic, in a locked room, or the medications are in a locked cabinet. All non-controlled medications are stored in a separate, secure, locked area inaccessible to youth. The narcotics/controlled substances are stored in a lock box, in the locked medication cart, in a locked room in the clinic. The medication cart is organized by youth, with over-the-counter (OTC) medications stored separate, as well as topical from injectable (only epinephrine autoinjector in the cart). The clinic has a separate refrigerator for medications, which there were none during the annual compliance review. Syringes/sharps were stored separately in locked drawers.

The program has written facility operating policy and procedures (FOP) indicating unused medications shall be returned to the pharmacy on a monthly basis. Medications shall be packed in a designated container with the Return to Pharmacy form. Stock medications shall be checked monthly to ensure return of drugs which have expired. Controlled substances shall be destroyed by the clinical manager/designee and consultant pharmacist on a monthly basis.

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

The program has written facility operating policy and procedures (FOP) which indicates if the medication/sharp count is incorrect, it shall be reconciled before the off-going staff is released from duty. If the count cannot be reconciled, the clinical manager/registered nurse (RN) shall be notified. An incident report shall be completed and submitted to the facility administrator before the off-going shift is released from duty. Controlled substances shall be destroyed by the clinical manager/designee and the consultant pharmacist on a monthly basis.

A review of the last six months of inventories indicated the syringes/sharps and the over-the-counter (OTC) medications were counted utilizing a perpetual inventory, as well as, at a minimum, a weekly inventory, with no discrepancies identified. A perpetual inventory with running balances and shift-to-shift inventories are also maintained on all controlled substances within each youth's Individual Healthcare Record (IHCR). A count of three sharps, three OTC medications, and three youth medications was conducted and were found to coincide with the inventory number.

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

The program has written facility operating policy and procedures (FOP) indicating all Drug Enforcement Agency (DEA) controlled substances require a perpetual inventory with running balances shall be maintained, as well as a shift-to-shift inventory.

A review of the Individualized Controlled Medication Inventory Record in each applicable youth's Individual Healthcare Record (IHCR) indicated the program documented shift-to-shift counts for the controlled substances. The program maintains a list of trained non-healthcare staff assisting in self-administration of medication only when healthcare staff are not on-site. A review of two controlled medication counts were observed and matched the inventory number documented; the program only had two on-site at the time of the annual compliance review. The controlled medications are maintained in a lock box, in the locked medication cart, within a locked room in the clinic.

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

In all seven records reviewed, the Medication Administration Record (MAR) included the youth's name, Department identification (DJJID) number, date of birth, allergies, precautions, and medical grade. All current MARs are maintained in a separate binder in the medication cart and include a form with a picture of the youth and other identifying information; all seven youth forms were reviewed and they all had a picture of the youth. Three of the eight youth reviewed were taking medications at the time of admission and the initial MAR matched the medication list. The MAR clearly indicated medication start and stop dates and staff initialed each administered

medication entry. No lapses/errors were found. The nursing staff documented weekly side effect monitoring on the MAR.

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

The program has written facility operating policy and procedures (FOP) regarding administration of medication. The staff shall observe the youth take medication(s), if prescribed on a dose-by-dose basis and shall request each youth open their mouth to visually check or swab the mouth to ensure medication is not cheeked. Licensed nursing staff shall only administer dosages of prescribed medications in the original packaging or container from the pharmacy who filled the medication. Only a licensed medical professional shall administer emergency prescription medication from a bulk container.

None of the seven reviewed records were applicable for parenteral medications. Observations of five youth medication passes determined it is a structured process. The nurse conducts medication pass in the hallway using the medication cart as a barrier for the doorway having the youth step up to the medication cart, state their name, and the medication they are taking. A direct care staff member brings one youth at the time out of the module to see the nurse and to observe the medication pass. The work space is clean, organized, and the nurse has control of medication containers and the medication cart. The nurse spoke to each youth, verified the medication in the bubble pack and on the Medication Administration Record (MAR), placed the medication in a small container and handed it, as well as a cup of water to each youth. After the youth took the medication, the nurse ensured he swallowed the medication by having each youth stick their tongue out and move it back and forth. The nurse then initialed the MAR. One of the youth refused the topical medication and signed a refusal of treatment form and the direct care staff signed as a witness.

Six of the seven interviewed youth indicated the nurse always conducts medication pass. There remaining youth report he does not take medication.

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

The program maintains a list of trained non-healthcare staff who are able to assist youth in the self-administration of medication when licensed healthcare staff are not on-site. In five of the seven records reviewed, each youth received medication administered by trained non-healthcare staff. In the other two the youth did not receive any medications administered by non-healthcare staff. In four of the five applicable records, the staff and youth initialed each of the multiple entries on the Medication Administration Record (MAR). In the remaining record, one medication pass was not initialed by the youth, but by the staff.

Seven staff interviews indicated all trained staff can assist with medication administration, as well as the supervisor, the doctor and the nurse. Out of the seven youth interviewed, one stated

he does not receive medications and the other six indicated the nurse always does medication pass.

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

The program has a comprehensive process in place for the monitoring of psychotropic medications, but does not have standing orders, emergency treatment orders, or pre re nata (PRN) orders for psychotropic medications.

One of the seven youth records reviewed was for a youth who was admitted with psychotropic medications. The program was only able to provide one extra applicable record for the annual compliance review period. In the two applicable records reviewed, the youth were admitted with psychotropic medications, the designated mental health clinical authority (DMHCA) was notified and the youth continued the prescribed medications until a psychiatric interview/psychiatric evaluation was completed within fourteen days of admission. In one of the records, a referral was made to the psychiatrist and after the evaluation, which was conducted within thirty days, the youth was placed on psychotropic medication. All youth are referred for a psychiatric evaluation upon admission to the program. Each of the eight reviewed youth records contained documentation indicating the youth received a psychiatric evaluation, which was completed on the Department form entitled "Clinical Psychotropic Progress Note" (CPPN) and page three was utilized. All of the psychiatric evaluations included the signature of the psychiatrist, as well as the date of the signature, within the first thirty days of admission. In two records, the results of the evaluation either initiated a new psychotropic medication or made changes to an existing one. In those records, the evaluation included the diagnosis, target symptoms of each medication, evaluation and description of effect of prescribed medication on target symptoms, prescribed psychotropic medications, side effects, youth adherence to medication, and telephone contact with the parent/guardian. Each youth received medication monitoring. One of the records was applicable for tardive dyskinesia monitoring which was documented on a monthly basis by the nursing staff.

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

The program has written facility operating policy and procedures (FOP) which includes procedures regarding infection control for common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis (TB), Hepatitis A, B, C and infectious diseases, other outbreaks or epidemics, outbreaks of lice and/or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA), Escherichia (E.) Coli, bio-terrorist agents and chemical exposure in the workplace. The FOP also included staff having access to protective equipment and staff being trained on universal precautions and personal protective equipment. The infection control procedures in place included prevention, containment, treatment and reporting requirements related to infectious disease, according to Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for

Disease Control and Prevention (CDC) guidelines. The program had to notify the Department of Health (DOH) due to youth being positive for sexually transmitted infections (STI).

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

The program has written facility operating policy and procedures (FOP) outlining a comprehensive infection control education plan including pre-service and in-service training for all staff, and youth. In all seven youth records reviewed the health education record documented training in prevention of communicable diseases and prevention of blood-borne pathogens. In seven in-service and seven pre-service training records reviewed, all staff completed infection control training.

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

The program has an exposure control plan which was reviewed and signed annually by administration and included risk assessment and methods of compliance, as well as needle stick post-exposure evaluation. The program maintains the exposure control plan in the clinic, accessible for all staff. The program has not had any facility/occupational exposure incidents nor three or more infectious diseases or ten percent or more of the program population having a contagious disease but would keep a folder in the clinic if any such events should occur.

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

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

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

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

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures which defines active supervision of youth as interacting positively with youth, engaging in full schedule of constructive activities, closely observing behavior and changes in behavior of youth, and consistently applying the behavior management system. Youth supervision was observed during each day of the annual compliance review while youth were engaged in free time on the dorm, class, recreation, mental health groups, treatment team, medical, prior to a transport, and on video engaged in dorm clean-up. Each observation found the program was adhering to their active supervision procedures with no youth unattended. The program was always within the contracted staff to youth ratio of one to six for the youth in the borderline developmentally disabled/developmentally disabled units and one to eight for the youth in the mental health overlay services youth units. Three staff were randomly selected and questioned at different times to provide the count of youth they were supervising and each correctly stated the number. The assistant facility administrator was interviewed and reported if a count is incorrect all movements and activities are stopped until the counts can be reconciled.

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

The program has a written policy and procedures outlining the provision of the behavior management system (BMS) which fosters accountability for behavior and compliance with rules and expectations and included all required elements, including a four-to-one ratio for positive and negative consequences. The BMS was created and is maintained by appropriate program and educational staff and is in compliance with the program's contract. The program has a contract with the Osceola County School Board which details the BMS as the required method for tracking youth behaviors and encouraging positive behavior in school. The teachers completed two training sessions regarding the BMS during the annual compliance review. Teachers consistently utilize the points for behavior, distribute "gotcha" certificates to youth engaged in positive behavior, and participate in the bi-weekly awards ceremonies. The BMS is detailed for youth in the youth handbook and explained during the orientation process. There is a developmentally appropriate BMS structure for the youth in disabled/developmentally disabled units and the mental health overlay services youth units which defines the expectations, points, levels, rewards, and consequences. The handbook specifies consequences associated with behavior infractions which is in direct relation to the severity of the infraction. Seven youth

records were reviewed, and each youth received an orientation to the BMS upon arrival to the program.

The BMS is tracked on sheets and updated daily for youth to notify them of earned points, levels, days until the next level, and other information. Youth are offered a variety of incentives, which includes daily incentive activities, later bed times, canteen items based on their level and earned points, increasing levels for additional privileges, and weekly awards in conjunction with school staff. A program tour found multiple postings of the BMS guidelines, incentives available, and tracking available for youth. In addition, observations were conducted and revealed staff consistently use the BMS to encourage youth to stay on track. Observations revealed staff use the four to one ratio of positive to negative consequences during interactions with youth.

Seven youth were interviewed, and each were able to explain the BMS they are engaged in based on their unit. The youth all described a variety of incentives, including daily incentive activities, pizza, ice cream, awards ceremonies every other Wednesday, and canteen. The seven youth consistently reported negative consequences in the program include early bedtime, time out, and level suspension. Seven staff were interviewed regarding the BMS; six staff reported the BMS is a point system, four reported the BMS is in the youth handbook, two detailed postings for the BMS are found throughout the program, and one staff mentioned the BMS is a level system and staff use a four to one ratio of positive to negative consequences. Staff confirmed youth are offered a variety of nightly, weekly, and monthly incentives. Further, staff indicated nothing can be taken away from youth as a consequence; however, incentives can be taken away, such as an earned music player and a later bedtime. The consequences and incentives utilized by the program was further confirmed through an interview with the facility administrator. Seven pre-service staff training records were reviewed, and each documented the staff completed training the program's BMS.

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

The program has a written policy and procedures outlining the provision of the behavior management system (BMS) which includes a process wherein staff explain to youth the reason for any sanction imposed, the youth is given an opportunity to explain his behavior, and staff and youth discuss the impact of the behavior, potential reparations, and alternatives. The BMS does not include an increased length of stay as a consequence, denial of youth rights, promotion of group punishment, or disciplinary confinement and room restriction. The program utilizes controlled observation for youth at a safety risk to themselves or others; however, room restriction as a consequence is prohibited. The BMS was created and is maintained by appropriate program and educational staff and is in compliance with the program's contract. Seven youth were interviewed and each described the BMS as good, staff are fair and consistent in the application of the BMS, and youth are never allowed to punish or exercise

control over other youth. Seven staff were interviewed and confirmed youth are given the opportunity to explain their behavior; three staff discussed special treatment teams where youth receive consequences for their behavior, three staff reported youth are given an opportunity to write their side of the story on their point card, two staff said youth are given three prompts before any points are taken away, and one staff inferred youth know the consequences of their actions based on the youth handbook and can tell their side of the story if they wish.

Fourteen staff records were reviewed and each included a position description which outlined the expectations for staff regarding the BMS. In addition, each of the fourteen staff records included a performance evaluation, completed within the last year, which rated the staff's usage of the BMS. Seven pre-service staff training records were reviewed and each included required training in the BMS. Six of the seven staff interviewed were able to discuss different methods for feedback on their usage of the BMS; one staff was a case manager and does not regularly utilize the BMS. The staff reported supervisors coach them during weekly one on one sessions, while staff are working the floor, and during shift briefing meetings. A shift briefing was observed and the shift supervisor discussed where the youth stood based on their points and who was eligible for the nightly incentive. The facility administrator was interviewed and reported consequences for youth are monitored in their individual treatment teams and with the administrative team during the daily morning meeting.

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

The program has a written policy and procedures for the provision of ten-minute checks which includes logging all ten-minute checks conducted on a paper check sheet which is initialed by the staff conducting each check and completed in real-time. Paper check sheets were reviewed for December 1, 2018 (Lakers mod), December 25, 2018 (Magic), January 6, 2019 (Suns), February 16, 2019 (Celtics), March 4, 2019 (Lakers), and March 28, 2019 (76ers). All checks were documented as occurring at intervals of no greater than ten minutes apart and appeared to be in real time. The check sheets often had blank spaces between checks which appear to show gaps in checks up to three hours during the daytime when youth may come out of their rooms for programming. Further, some of the sheets showed long gaps without a blank space in between. The program reported, and the schedule and logbooks indicated, youth are not in their rooms at this time. The program provided a corrective action memo during the annual compliance review which instructed staff to write "out" when youth are not in their rooms between checks. Ten-minute check sheets also appeared to start on the evening of one date and extend to the next day; however, this is not documented clearly on the checks sheets as a.m., p.m., and the start of the next date. The form was amended during the annual compliance review to prompt staff to record a.m. or p.m. and when the next day begins on the form.

The program has sixty-one cameras, fifty-nine of which are operational. Two additional cameras are blurry and difficult to view. Each of the four deficient cameras are located in the youth dorms. The cameras are able to store thirty days' worth of footage. Six time periods across each youth dorm were reviewed on video with the assistant facility administrator (AFA). Reviewed video for April 7, 2019 on the 76ers dorm, April 22, 2019 on the Celtics dorm, and April 27, 2019 on the Lakers dorm found staff were appropriately completing ten-minute checks and the

documented checks matched the observed checks. Video reviewed for April 9, 2019 from 4:00 a.m. - 5:00 a.m. on the Magic dorm, found the checks were observed to correspond with documented checks; however, the staff were observed only glancing into the rooms. On April 4, 2019 from 6:00 p.m. - 7:00 p.m. on the Lakers dorm, the staff documented checks occurred at 6:03, 6:12, 6:30, 6:39, 6:48, and 6:57; however, the video showed staff only completed the 6:03 p.m. check. The video skipped between 6:10 and 6:13; therefore, the 6:12 check could not be verified. For each of the other checks, the staff can be seen in the hallway with youth but did not conduct ten-minute checks on the youth still in their rooms. At the end of the video, all youth can be seen exiting their rooms and congregating in the dayroom. On April 20, 2019 from 10:00 p.m. - 11:00 p.m., a check was documented as occurring at 10:32 p.m.; however, the video showed this check was not completed. On the same evening, a staff documented a check occurred at 10:59 p.m.; however, the check was not conducted and the staff who initialed the check was seen on video leaving the dorm during the time period the check was documented as occurring. On April 24, 2019 from 6:15 - 7:15 a.m. on the Celtics dorm, checks were documented as occurring at 6:08, 6:15, 6:24, 6:32, 6:41, and 6:50; however, checks were only observed as occurring at 6:08 and 6:21. The Central Communications Center (CCC) was contacted by the AFA who observed the video with the review team regarding the falsification of checks. Seven staff interviews were conducted and each reported checks are conducted every ten minutes anytime a youth is behind a locked door.

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

The program has a written policy and procedures which outlines the requirements for maintenance of the program census and population counts during each shift. The program tracks the census in master control, in the conference room, and in the logbook. The logbook documents daily census, head counts, movements, youth transports, youth away from the program, admissions, and released. A review of the program logbook found counts were conducted multiple times on each shift, including at the beginning of each shift and multiple unscheduled times throughout each shift, as outlined in their policy and procedures. In addition, documentation was found counts are also conducted after recreation, after codes, and after drills which is in compliance with the program's Continuity of Operations Plan (COOP). Counts were observed to be conducted at several times during the annual compliance review and they were completed, as required. Seven staff were interviewed and each reported counts are conducted every hour, and after an emergency or drill. Further, staff explained if there was a discrepancy in the count, all movement would stop until the count could be reconciled.

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 maintains a logbook in master control in a bound book with designated pages to complete for each shift, including youth counts, admissions, releases, youth on precautionary observations, staff on shift, movements, major behavior incidents, and other pertinent information. The logbooks were reviewed for the last six months and found all pages are dated, completed in ink with no erasures or white-out areas, errors are struck through with a single line and initialed, and all entries include required information. However, a review of the logbook found numbers were consistently overwritten throughout the logbooks, including youth counts. Five Central Communications Center (CCC) reports were reviewed and each was found in the logbook. One of the five controlled observation incidents reviewed were documented in the logbook. The program provided counseling memos, a termination form, and two resignation forms to demonstrate the master control staff responsible for maintaining the logbook during the annual compliance review period had recently had a turnover of staff and were being held accountable for the mistakes in the logbook. In addition, the program began holding master control meetings, in which topics such as the appropriate documentation to be maintained in the logbook, is discussed and provided meeting minutes to the review team. The program also utilizes shift reports which are utilized to brief oncoming staff of events which occurred during the previous shift. Shift reports were reviewed and included all required information. Shift reports are maintained in master control for review and submitted to the assistant facility administrator (AFA) monthly. A shift briefing was observed during the annual compliance review and included all required information and documented on a shift briefing form which was signed by all staff present at the briefing. In addition, master control was observed documenting in the logbook in real time throughout the annual compliance review.

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 written policy and procedures in place regarding key control which includes all required components. The program maintains a perpetual key log to track keys being checked in and out as well as a key inventory which is reconciled on a weekly basis. A shift change was observed and it was found staff turn in personal keys upon arrival, are searched, and then take possession of program keys from the staff member they are relieving and then call in their assigned keys. Personal keys are hung in the key box on the ring associated with the program key assigned to the staff member. For case managers and teachers, there is a key for key system in place where staff turn in personal keys and obtain assigned program keys. Restricted keys are maintained in a separate key box in master control (MC) which is only accessible by MC operators and program administration. The restricted keys are each labeled

with the staff allowed to access them. The MC operator and assistant facility administrator (AFA) were interviewed and they described the process for addressing broken keys as the MC operator completing a form to notify the keys need to be fixed. The interviews also revealed if a key is discovered to be lost or missing the youth are locked down, an emergency head count is conducted, the appropriate notifications are made, and the youth remain locked down while the key is searched for. Three staff, a youth counselor, a case manager, and the AFA, were checked for personal keys and each of their personal keys were found in the key boxes. In addition, each staff's assigned program keys matched the key inventory and each key ring had the appropriate keys. Seven staff were interviewed and each reported personal keys are securely stored and staff keys are issued upon entry; six staff inferred keys are assigned to staff and if keys are missing they report it to MC; five staff reported youth do not have access to keys, visitors' personal keys are securely stored and they are given a chit, and there is daily tracking of keys. In addition, four staff reported if a key were missing they would call the Central Communications Center (CCC) and three staff reported if a key was broken they would ask MC to fill out the broken key form.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.* *The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement.*	

The program has a written policy and procedures regarding contraband which establishes a system to prevent the introduction of contraband into the program includes all required components. In addition, the program documents requirements for staff regarding contraband and the consequences for violation of the policy, up to and including termination, in the policy and procedures, as well as the staff handbook. Youth are provided a list of contraband items and consequences for violation in the youth handbook at orientation. Searches for contraband occur as required through multiple searches of youth throughout the day and daily contraband room checks. Contraband found is confiscated from youth and discarded, if not illegal, and documented in the search binder. Each search, outside of normal movement searches, are documented on a form which reports the date, time, youth, which type of search was conducted, and what was found. All contraband searches are documented in binders maintained for each dorm. The facility administrator was interviewed and reported any illegal contraband would be immediately turned over to the sheriff's office; however, the program has not had incidents of illegal contraband found during the annual compliance review period. Any legal contraband is secured in the facility administrator's office, photographed, and maintained until any internal investigation is complete and then disposed of off-site. The program had five Central

Communications Center (CCC) reports in the last six months regarding contraband and there was evidence the program maintained compliance with their policy and procedures.

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

The program has a written policy and procedures in place regarding the search process for youth, staff, and visitors. All staff and visitors are searched upon entry for contraband. Searches for visitors are documented on the visitation sign-in log. Youth are searched before and after school, after recreation outside, during admission, before and after transports, and after any vocational activities. Searches conducted before a transport, after mental health group, after youth met with a member of the review team, and before school was observed and each complied with all search requirements. The searches were conducted by staff of the same gender in a manner which minimized the youth's stress and embarrassment. All searches were conducted based on the Protective Action Response (PAR) manual. Seven youth were interviewed and six reported searches are done with every movement; one youth did not want to answer the question and then reported searches are hardly ever done. Seven staff were interviewed and each reported searches are conducted with every movement.

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

The program has a policy and procedures to ensure all vehicles transporting youth receive appropriate maintenance and contain safety and emergency equipment to be operated in a safe manner. There were two vehicles reviewed and both are used to transport youth. Both vehicles have a fire extinguisher which were inspected March of this year. Each vehicle has a seat belt cutter and window punch on the keychain and first aid kits for each are accessible to drivers inside the facility and remain out of the heat until a transport is made. Both first aid kits have a list of contents and have been inspected. Both vehicles have had an annual inspection in February 2019 with any deficiencies corrected and there is a sufficient number of seat belts in the vehicles. Program vehicles are kept locked when not in use.

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

The program has a policy and procedures in regard to the process staff are to take when transporting youth. One youth was observed being transported by one male staff and one

female staff. The transporting staff were provided with communication devices during transport. Both staff and the youth wore seatbelts. Youth are not attached to any part of the vehicle when they are transported. A cellular phone and radio are issued for use by the transporter. Youth are not left unsupervised in the vehicles and youth are not permitted to drive program or staff vehicles.

According to seven staff interviews, personal vehicles of staff are not used for youth transport. All program and staff vehicles are kept locked when not in use. When five or less youth are transported, two staff perform the transport with one staff being the same sex as the youth. One additional staff transports when more than ten youth are transported. The transporting vehicles have safety screens separating the front seat from the passenger compartment and the interior doors cannot be opened from the inside. There are five staff, from the staff driver list, which transport youth and have current driver license most recently checked April 2019.

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

The program has a policy and procedures which outlines safety audits and inspections. The facility administrator is responsible for conducting the weekly audits. There have been no necessary corrective actions applicable in the past six months. The program has a system in place to make improvements when a need is identified. The program had six months of audits reviewed and completes audits every seven days, as required. There were two audits performed eight days apart: one from March 12, 2019 to March 20, 2019 and the other from January 9, 2019 to January 17, 2019. The program has a process regarding identification, tracking and addressing deficiencies which is also communicated by the assistant facility administrator in daily management meetings.

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

The program has a written policy and procedures regarding the inventory and management of tools which includes procedures for instances of missing or lost tools. All class A tools were observed to be kept in the locked maintenance shed which is in an area inaccessible to youth, outside of the facility. The shed is only able to be accessed with use of a restricted key issued to the physical plant manager and administration. The shed includes a board with an outlined spot for each tool. All tools are labeled with a unique number which corresponds to the inventory. One tool, the level, was observed to be broken. The physical plant manager explained when a tool is broken, a broken tool form is completed and the broken tool remains on the board until it can be replaced in order for the inventory to always match tools on-site. The dysfunctional tool is disposed of once a replacement tool is purchased and labeled. The tool inventory for class A tools is completed on a daily basis and was completed daily when the physical plant manager was on-site to account for all tools, for the last six months; however, the physical plant manager does not sign the tools out when used. The inventories were not signed by the facility administrator. The physical plant manager reported he used to log the tools in and out; however, he no longer does. The program provided a corrective action for the physical plant manager and provided copies of the sign-in and out log completed during the last annual compliance review which will now be utilized again moving forward.

The food services manager maintains an inventory and sign-out log for the knives and utensils which was found to be maintained on a daily basis for the last six months. The knives and utensils are kept in a locked box in a filing cabinet inside the food services manager's office in the kitchen, which is inaccessible to youth. Class B tools are kept in the maintenance shed, kitchen, and in the laundry rooms on the dorms. Each are inaccessible to youth and accompanied by a sign-in and out log as well as an inventory which is completed on a monthly basis. There were no prohibited tools on-site. Seven pre-service staff records were reviewed and each included tool training. Seven youth case management records were reviewed and there was no evidence of tool training. The assistant facility administrator (AFA) was interviewed and reported youth only use class B tools and they are not provided special tool training.

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 outlining the requirements for youth tool handling and supervision which includes all required components. Risk assessments were found for all youth prior to the use of tools; however, one was completed during the annual compliance review. The program maintains a one staff to five youth ratio during all projects which include the use of tools. Youth are only allowed to handle class B tools. An interview with the assistant facility administrator (AFA) revealed if a youth is assigned to a work project they must have a completed risk assessment, are searched prior to usage, supervised during the project, and are searched after the project. For the use of mops and brooms, staff are to check the tool out, supervise the youth while in use, and then sign the tool back in. When reviewing video from April 4, 2019, youth were observed utilizing mops and brooms in their rooms with the door mostly closed while staff were in the hallway but not directly supervising the youth. Additional observations of youth use of mops and brooms was not able to be conducted during the annual compliance review. The program's policy states class B tools must be used under the direct supervision of staff.

Seven staff were interviewed and each reported youth are only allowed to use mops and brooms; three staff reported youth are also allowed to use scrub brushes. Five of the staff further stated youth must complete a risk assessment prior to use and youth can only use class B tools. Seven youth were interviewed and six reported youth use mops and brooms, three reported youth also use scrub brushes, and one youth reported youth do not use tools at all.

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 for signing in contractors when work is completed in the facility and for documenting the staff responsibility for approval of electronic devices and tools used. The sign-in sheets were reviewed for contractors, as well as eight invoices. The sign-in sheets are signed by the staff and contractor with dates, times, tools checked upon arrival and departure, tool restrictions while inside the facility, youth restrictions from the work area and missing tool follow-up. The only exceptions found were on January 11, 2019, the contractor signed in, but the form was not completed for the tools or check out time and it was not signed by the staff. Additionally, an invoice from Facility Services for February 18, 2019 had no sign in sheet.

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

The program conducts practice drills for fire, safety, evacuation and disaster and is prepared for mobilization in the event of a disaster. In response to frequency of fire drills, the facility administrator advised they are performed monthly and are documented with the type of drill, date and time, participants, a brief scenario and any findings or recommendations for future drills/events. There were six months of drills reviewed. Unannounced fire drills are performed at least monthly. The program has fire evacuation routes and egress plans posted throughout the facility and the youth are instructed on the evacuation process. In interviews with seven staff, the staff advised they participate in the following drills: weather, major disturbance, bomb threat, escape, hostage, terrorism, medical, tornado, suicide, and fire drills. Youth are instructed what to do in the event of a drill according to seven youth interviews.

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

The program has a Continuity of Operations Plan (COOP) posted in their master control as well as the facility administrator's office, is available to all staff, and includes all the necessary elements. The program's COOP was reviewed on March 20, 2019 and approved on March 25, 2019. The plan addresses alternative housing for disaster implementation and equipment and supplies for continuous operation during emergency situations.

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

The program has a written policy and procedures regarding the storage and inventory of chemicals, which includes the staff authorized to access the items. Chemicals are maintained in the maintenance shed which is secured by a restricted key only accessible by the physical plant manager and program administration. Cleaning chemicals are kept in a closet in the main hallway, which is secure with a restricted key only issued to the physical plant manager, administration, and supervisors when needed and signed out from master control. Supervisors are able to put chemicals they need for dorm clean-up in a bucket, sign out the chemicals, take the chemicals to the dorm for use, and sign them back in when completed. Inventories were found in the shed and the cleaning closet and each match the supply on hand. The program had four boxes of cleaning chemicals in the shed which had not yet been put into the inventory; however, the items arrived the same morning the inspection of the chemical area occurred. Safety Data Sheets (SDS) were found for all chemicals in the cleaning closet. In the maintenance shed a SDS was found for each chemical except seven. The program provided a new SDS for each item which was then placed in the binder in the maintenance shed.

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

The program has a written policy and procedures regarding the youth handling and supervision of chemicals. Chemicals are maintained in the maintenance shed which is secured by a restricted key only accessible by the physical plant manager and program administration. Cleaning chemicals are kept in a closet in the main hallway, which is secure with a restricted key only issued to the physical plant manager, administration, and supervisors when needed and signed out from master control. All chemicals and hazardous materials are inaccessible to youth. The assistant facility administrator (AFA) reported youth do not handle any toxic, flammable, and poisonous materials; however, they are able to wipe up the cleaning chemicals which are only controlled by staff. An observation of youth conducting a clean-up utilizing cleaning chemicals was not able to be observed during the annual compliance review.

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

The program has a written policy and procedures regarding the disposal of hazardous materials, which includes the provision of the maintenance staff being solely responsible for the disposal of these materials. The policy further states any disposal must comply with the Occupational Safety and Health Administration (OSHA) standards. The business manager reported they had not disposed of anything during the annual compliance review period as all of their chemicals are used. The program has a contract with Brownies Septic and Plumbing beginning March 29, 2019 and they were scheduled to come out for grease disposal in May. The program reported prior to this contract another company was used; however, grease disposal had not occurred for some time with the previous company.

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

The program has a policy and procedures in regard to recreation and leisure activities for the youth. The program provides a choice of leisure and recreation options which promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation and physical fitness. The program has activities such as gardening, physical games, yoga, and interactive communication. The only exception was the logbook documenting dinner being held instead of recreation between 4:30 p.m. and 5:30 p.m. (random dates reviewed were from January through April). The program indicated they would immediately revert to adherence to the posted schedule. The youth are encouraged to explore interests and engage in constructive use of leisure time. They are also provided a student council opportunity to promote constructive input by the youth. A recreational activity was observed to ensure precautionary physical safety

measures are taken. The activity provided is incorporated in the youth performance plans. All seven interviewed youth indicated youth are given one hour of large muscle activity daily and varying degrees of mental and physical exertion throughout the day. The program has a recreation therapist who has a bachelor's degree in exercise science.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a visitation and communication policy and procedures. The schedules and logs for visitation, telephone, and mail correspondence were reviewed. Saturdays and Sundays from 1:00 p.m. - 4:00 p.m. are visitation hours. Seven youth reported in interviews they are given opportunities to have correspondence by any of these options with the approved list of contacts. Generally, youth are given the opportunity to make calls three to four times a month according to the logbook documentation.

5.24 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 written policy and procedures regarding the use of controlled observation, which was put in place January 2019. The program had twenty controlled observations since January 2019. Five instances of controlled observations were reviewed and each documented the youth and the controlled observation room were searched prior to the placement of youth in the controlled observation room.

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

The program has a written policy and procedures regarding the use of controlled observation (CO), which was put in place in January 2019. The program had twenty instances of controlled observation since January 2019. Five instances of controlled observations were reviewed and documented a reason for the use of CO, approval of the CO by the facility administrator or designee, and a health status checklist completed by a registered nurse. Four of the youth were applicable for CO lasting beyond two hours and each CO report documented the extensions were granted by the facility administrator or designee. None of the CO instances documented the youth was advised of the reason for CO and the expected behavior for return to regular programming. Each of the five CO instances were reviewed by the facility administrator within the required timeframe.

5.26 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 written policy and procedures regarding the use of controlled observation (CO), which was put in place in January 2019. The program had twenty controlled observations since January 2019. Five instances of controlled observations were reviewed and each included a completed report by the staff making the placement. Checks were maintained on each youth at a minimum of fifteen-minute intervals on the Controlled Observation Safety Checks form. The youth was removed from CO in each instance by the facility administrator or designee and reviewed by the facility administrator within twenty-four hours. Three of the five youth records documented the youth was released from CO based on their behavior. The additional two records reflected youth were “released to the shower” and did not document conversations with or behavior of the youth which led to the facility administrator authorizing the youth’s release.

Program Name: Kissimmee Youth Academy
Provider Name: Youth Opportunity Investments, LLC
Location: Osceola County / Circuit 9
Review Date(s): April 30 - May 3, 2019

MQI Program Code: 1426
Contract Number: 10287
Number of Beds: 71
Lead Reviewer Code: 148

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.13 Suicide Prevention Training*	5.04 Ten-Minute Checks*
5.25 Controlled Observation	5.13 Tool Inventory and Management