STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Kissimmee Youth Academy: Borderline Developmentally Disabled/Developmentally Disabled

Youth Opportunity Investments LLC
(Contract Provider)
2330 New Beginnings Rd.
Kissimmee, Florida 34744

Review Date(s): January 14-17, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Kamille Payne, Office of Program Accountability, Lead Reviewer, Standard 1
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Program Name: Kissimmee Youth Academy: Borderline Developmentally Disabled/Developmentally Disabled
MQI Program Code: 1426
Provider Name: Youth Opportunity Investments LLC
Contract Number: 10287
Location: Osceola County / Circuit 9
Number of Beds: 47
Review Date(s): January 14-17, 2020
Lead Reviewer Code: 161

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.06 Logbook Entries and Shift Report Review	
5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Kissimmee Youth Academy: Borderline Developmentally Disabled/Developmentally Disabled is a forty-seven bed program, for fourteen to nineteen year old males, located in Kissimmee, Florida. The program is operated by Youth Opportunity Investments LLC, through a contract with the Department. The program provides Borderline Developmentally Disabled/Developmentally Disabled services. In addition, the program fosters each youth by providing Skillstreaming the Adolescent, Trauma Focused-Cognitive Behavioral Therapy, Young Men's Work/Teen Relationships, and Impact of Crime. Additional treatment services provided includes individual therapy, family therapy, group therapy, and recreational therapy. Program administration is comprised of a facility administrator, three assistant facility administrators, director of case management, designated mental health clinical authority, and clinic nurse manager. Case management services are provided by the director of case management, five case managers, and two transition case managers. Mental health staff at the program includes the designated mental health clinical authority, who is a licensed mental health counselor (LMHC), an assistant clinical director who is also an LMHC, six master's-level non-licensed therapists, and a contracted psychiatrist, psychologist, and certified behavioral analyst. Medical services are offered daily and are provided by two registered nurses and a contracted designated health authority who is a licensed medical doctor. The program utilized four registered nurses (RNs) during the annual compliance review period in which two are still employed with the program. Each RN had current and active licenses in the State of Florida expiring on July 31, 2020 and April 30, 2021. Educational services are provided by the Osceola County School Board. The layout of the program includes: one building which has two wings separated by a common hallway which houses medical, staff offices, the staff break room, and the administrative area. The program is located on one side of the program which includes three living units, two of which are currently occupied. The other wing is occupied by youth in the program co-located in the building under the same Department contract. The program has ninety-nine operating security cameras providing coverage and one which is not functional due to damage sustained when the new camera system was installed. At the time of the annual compliance review, the program had nine vacant positions; four youth care worker Is, four youth care worker IIs, and the recreation therapist.

Strengths and Innovative Approaches

- The program has revamped their student council program which requires youth to apply and be chosen to represent their peers. The student council has cultivated many creative and innovative ideas, like Distinguished Gentleman, potlucks, and having input on the family day themes. Through the Distinguished Gentleman program, not only can youth earn the privilege to participate in the evenings of fellowship, the men of Alpha Phi Alpha have provided volunteers to interact with youth on family day who may not get a visit.

- The program has begun bringing the Florida Licensing on Wheels mobile on-site to issue Florida identification for the youth while they are in transition.

- During the annual compliance review period, the program started an animal program. The program has one dog who sits with the youth during phone calls and has played at recreation with the youth. The dog will begin training on January 27, 2020 to become a certified support dog. Education also has two dogs who attend school with the youth and add a calming effect to the class. The program has partnered with Lowes to have a chicken coop built with all donated labor and materials. Eligible youth were able to complete community service hours by assisting in the construction of the chicken coop and a goat habitat. The program has incubated and successfully hatched five baby chickens. The program was also the recipient of three goats who function to assist in the lawn maintenance at the program and will be show animals to help the youth establish a 4-H program where youth learn to show the goats at the local fair. The program is also currently developing Koi ponds for an aquaponics garden.

- Last summer, the program started an advanced manufacturing class, a high need occupation in Florida, through cooperation with the Osceola County School Board. The program's school applied for and received a $66,000 federal Perkins grant to dual enroll select students with a local technical college which allows them to work towards certification and experience hands-on practice. The program recently received judicial permission for students to go off-campus to the technical college and began a Saturday class. Students learn online during the week and on Saturdays, the college teacher comes to the program to teach the curriculum, students then apply what they have learned during field trips on Saturdays to the technical college. Hours earned in the program will be articulated back to their home community technical college for further education. Not only is the program now accredited but will soon be an extension of Osceola Technical College as well.

Standard 1: Management Accountability

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

The program has a policy and procedures in place regarding the background screening process for all newly hired staff. A review of the staff and contractor roster found the program hired twenty-six new staff during the annual compliance review period, each of which had a completed and eligible background screening in the Agency for Healthcare Administration Clearinghouse system. Each screening was received prior to the hire date for each staff. A review of each of the staff's personnel records found the program reviewed each staff's criminal history report, Staff Verification System (SVS) report, Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS), and Central Communications Center (CCC) Person Involvement report prior to hire. Each staff also had documentation they completed and passed a pre-employment assessment tool. None of the newly hired staff required an exemption prior to working with youth and did not have a break in service indicated in the SVS. One staff was hired after working with another provider and documentation confirmed a background screening was completed for this employee. A review of the program's volunteer roster and sign-in logs verified the program did not have any volunteers which required a background screening. The program did not employ interns during the annual compliance review period. The program utilizes teachers from the Osceola County School Board. The school board and the program submitted their Annual Affidavits of Compliance with Level 2 Screening Standards to the Department on January 18, 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 in place to submit a background rescreening to the Agency for Healthcare Administration Clearinghouse system for staff every five years of employment. A review of the staff and contractor roster found no staff eligible for a five-year background rescreening.

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

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

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

The program has a policy and procedures in place to establish an abuse-free environment for youth and staff, including the provision for staff to sign a Code of Conduct upon hire. The policy outlines the requirements of staff to offer youth unhindered and immediate access to the Florida Abuse Hotline by immediately notifying a supervisor to facilitate the call anytime a youth wishes to contact the hotline. The policy confirms notification to other program staff, including the facility administrator, should not hinder the youth's ability to call the Florida Abuse Hotline. Observations made during the program tour found the program has postings for the Florida Abuse Hotline, as well as contact information for the Central Communications Center (CCC) for youth over the age of eighteen, throughout the program. The facility administrator was interviewed and verified the youth have unhindered access to the Florida Abuse Hotline and the staff are required to sign an Affidavit of Good Moral Character for their code of conduct upon hire.

A review of all twenty-six newly hired staff personnel records verified each staff signed an Affidavit of Good Moral Character upon hire which outlines the expectations for all staff to create an abuse-free environment. The program had two allegations of staff abuse during the annual compliance review period, both of which were found to be unsubstantiated. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment and documentation found the program used the results of the assessment to incorporate trauma-responsive principles into the program planning process. Five youth interviews were conducted and each reported feeling safe in the program. In addition, each youth reported they had never been hindered from calling the Florida Abuse Hotline and staff were respectful to them and other youth. Three of the youth reported never hearing staff use profanity while one youth reported staff used profanity on one occasion when a youth repeatedly did not follow directions and one youth said staff use profanity occasionally but could not recall a specific situation. Five staff interviews were conducted and each staff reported staff have never hindered a youth from

contacting the Florida Abuse Hotline. Each of the staff described this process as staff contact the supervisor and facility administration and allow the youth to make the call. Three of the staff said any staff are allowed to make the call and three staff reported the supervisor makes the call. Four of the interviewed staff reported staff never use threats, intimidation, or profanity, and one staff reported staff occasionally use profanity; however, it is never directed at the youth. A review of incident reports and youth records found no instances in which the Florida Abuse Hotline should have been called. Observations, documentation, and youth and staff interviews verified the environment is free from physical, psychological, and emotional abuse.

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

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

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

The program had eleven incidents reported to the Central Communications Center (CCC) during the previous six months, five of which were reviewed. Each incident was reported to the CCC within the required two-hour timeframe. Four of the incidents were found documented in the program logbook with the CCC incident number. The fifth report was documented in the logbook for the accompanying Florida Abuse Hotline call and youth arrest; however, the CCC was not mentioned. A review of internal incident reports, grievances, and youth records was conducted and found no instances in which the CCC should have been contacted. The facility administrator was interviewed and reported all staff have access to call the CCC; however, standard procedure is for an assistant facility administrator or supervisor to contact the CCC within two hours of discovery of the incident.

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

The program has a Protective Action Response (PAR) plan which was approved by the Department on January 9, 2019. Additional documentation supported the PAR plans are submitted to and approved by the Department annually. The program had nine incidents in which PAR techniques were utilized during the annual compliance review period, which was a decrease from the previous annual compliance review period. The program's PAR rate during the annual compliance review period was 2.55, which is above the statewide Residential PAR rate of 2.41.

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

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

The program has a pre-service training plan which was submitted on January 19, 2019 and approved by the Department's Office of Staff Development and Training on February 7, 2019. The program utilizes youth care workers, class I and II, to serve as direct-care staff. Five staff training records were reviewed for pre-service and certification training requirements. Each of the five staff completed the required trainings in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, suicide prevention/intervention, emergency procedures, and Prison Rape Elimination Act (PREA) within 180 days of hire and prior to contact with youth. Each staff completed over 120 hours of pre-service training. Four of the staff also completed the required training in child abuse reporting and active shooter training, the fifth staff was still within the first 180 days of hire. The program's contract outlined additional training required of the pre-service staff. Each of the five staff completed eight of the ten additional contract trainings in areas of behavior, development, trauma, victimization, and gender responsive services. Two of the staff completed the other two contract trainings in restorative justice and staff stress management; however, the other three staff did not have documentation of completion for these contract trainings. All completed training was documented in the Department's Learning Management System (SkillPro). Documentation was provided and showed all staff who provided training in CPR/first aid, AED, and PAR were certified to facilitate the trainings.

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

The program has an in-service training plan which was submitted on January 19, 2019 and approved by the Department's Office of Staff Development and Training on February 7, 2019. The program utilizes youth care workers, class I and II, to serve as direct-care staff. Five staff training records were reviewed for in-service training and each of the five staff completed in excess of forty-hours of training. Each of the five staff completed required training in

cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, and suicide prevention. Two of the five staff completed active shooter training. Two of the staff were supervisors and both had documentation of eight hours of supervisory training in the areas of management, leadership, personal accountability, and communication skills. All completed training was documented in the Department's Learning Management System (SkillPro). Documentation was provided all staff who provided training in CPR/first aid/AED and PAR were certified to facilitate the trainings. The program maintains an annual in-service training calendar which is used to schedule and track annual training and is updated as needed.

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 in place which outline the grievance process. The policy documents the grievance process includes three phases; an informal phase through communication between youth and staff, a formal phase in which a youth files a written grievance and supervisory-level staff respond within two days, and an appeal phase in which the facility administrator reviews the resolution within two days. During the program tour, observations verified the program had grievances stocked and a grievance box for submittal on each living unit. The grievance process was verified through an interview with the facility administrator. The program maintains copies of all grievances for at least twelve months. The program had two grievances during the annual compliance review period, each of which were reviewed and found to have been resolved within the appropriate timelines. Five pre-service training records were reviewed and found each staff completed training in the grievance process. Five youth were interviewed and each reported the grievance forms are kept in the living unit, four youth reported there were timeframes to respond to the grievances, and three discussed giving the forms to staff. Five staff were interviewed and each reported forms are kept throughout the program, staff will help youth fill out the forms if needed, and the grievances are required to be responded to within certain timeframes. Three staff reported supervisors respond to the grievances and three staff reported the facility administrator responds to the grievances. Two of the staff reported there are three phases in the grievance process. The annual compliance review team addressed the grievance responses with program administration as none of the youth and only two staff were able to identify the process included three phases.

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

The program's contract outlines four group interventions which must be delivered to the youth, Skillstreaming the Adolescent, a practice with demonstrated effectiveness, Life Skills Training (LST), an evidence-based practice, and Impact of Crime, a promising practice. LST was not offered to the program youth during the annual compliance review period. The program contract

requires LST to be delivered by a master's-level clinician trained in the modality to the program's Borderline Developmentally Disabled/Developmentally Disabled (BDD/DD) population. The other program housed in the same facility for youth requiring Mental Health Overlay Services (MHOS) continued to utilize LST delivered by a case manager. In October 2018, the only therapist qualified by the program's contract to deliver the LST curriculum to program youth resigned. The program reached out to the Department for a training; however, the Department did not have an LST trainer. In July 2019, the program hired a trainer to complete an Action Plan with the Department, which was submitted in November 2019. Training in LST was conducted January 3 and 4, 2020 and the program began offering LST January 8, 2020. The other three delinquency interventions were offered throughout the annual compliance review and the group schedule and group sign-in sheets verified the groups were delivered as required, including the correct number of days each week, as outlined in the program's contract. A review of the program's activity schedule documented youth are involved in structured and planned programming for over sixty percent of their day, which includes school, groups, recreation, and structured leisure time.

Five youth records were reviewed, three of the youth were receiving three delinquency interventions and two were receiving four delinquency interventions. Each youth was involved in at least one delinquency intervention which addressed a priority need identified on the youth's Residential Assessment for Youth (RAY) and the youth's performance plan. The program contract requires the Skillstreaming, LST, and TF-CBT curriculum to be delivered by master's-level clinicians to the program's BDD/DD population. Group sign-in sheets found five master's-level non-licensed clinician and one licensed clinician facilitated delinquency groups during the annual compliance review period and each had documentation of training in the curriculum. Three case managers and one assistant facility administrator facilitated groups for Impact of Crime during the annual compliance review period, each of which had a bachelor's degree and training in the curriculum. Each of the ten staff members who facilitated groups during the annual compliance review period had the appropriate education, experience, and training in the curriculums they delivered. An interview with the facility administrator and designated mental health clinical authority confirmed which groups are offered and staff responsible for delivering groups to the youth. In addition, the facility administrator reported education and experience are factored into selecting who will facilitate groups. Five youth were interviewed and each reported they participate in multiple groups including Skillstreaming the Adolescent, IOC, and TF-CBT.

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

The program has a policy and procedures requiring all youth to receive life and social skills training while they are in the program. The program youth receive life and social skills services through Skillstreaming the Adolescent groups which help youth develop skills in communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. The activity and group schedule verify the Skillstreaming groups are offered twice a week. The program's contract also requires the program to offer Life Skills Training (LST); however, the program staff qualified to deliver the curriculum resigned. The program received training in LST through a contracted trainer January 3 and 4, 2020 and began offering LST January 8, 2020; however, the LST curriculum was not offered during the remainder of the annual compliance review period. All life skills groups are required by the program's contract to be delivered by master's-level clinicians. Documentation was found each staff member offering

life skills groups had the appropriate education, experience, and training. An interview with the designated mental health clinical authority (DMHCA) confirmed all youth receive life skills training and only staff qualified by the program's contract deliver life skills groups to the youth. Five youth were interviewed and each reported they are involved in multiple groups including Skillstreaming the Adolescent. Each youth identified skills they were working on and reported they practice these skills through role play in group.

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

The program's contract outlines restorative justice principles should be utilized throughout the program for youth. In addition, the program's contract requires the youth to receive Impact of Crime (IOC). Five youth records were reviewed and two of the youth were actively engaged in IOC programming while one previously completed the curriculum. The other two youth will receive IOC before they leave the program. IOC was delivered by three case managers and an assistant facility administrator, each of which had the appropriate education, experience, and training to deliver the curriculum during the annual compliance review period. In addition to IOC, the program provides opportunities for youth to engage in restorative justice, including earning credit towards their court-ordered community services hours, through cleaning and work projects around the program. During the annual compliance review period the youth helped paint the interior of the facility and build shelters for the program's new animal residents, three goats, five chickens, and a guinea fowl. The program also places an emphasis on reparation after any incidents to help foster restorative justice principles. The restorative justice activities offered at the program are designed to assist youth to accept responsibility, teach youth about the impact of crime, expose youth to the victims' perspective, and provide youth the opportunity to plan and participate in reparation activities. The facility administrator was interviewed and confirmed youth receive restorative justice education through IOC groups and community service projects. Five youth interviews were conducted and each reported participating in groups; three youth identified IOC as a group they had participated in. The team was unable to observe the youth engaging in restorative justice activities during the annual compliance review as IOC was not facilitated and community service projects were not completed while the team was on-site.

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

The program's contract outlines the use of a combined curriculum in Young Men's Work and Teen Relationships to serve as the program's gender-specific services. A review of the program's activity schedule, group schedule, and group sign-in sheets confirmed the group was delivered as required. The group is designed to target the male population of the program and address their developmental needs. An interview with the facility administrator and designated mental health clinician authority verified the youth are offered this combined curriculum to address gender-specific needs. Five youth were interviewed and each confirmed they participate in groups; four youth identified Young Men's Work as one of the groups they received. In addition, the youth participate in the Fab Five, which is a group of five youth from

the program, voted on by their peers, who are eligible to engage in an incentive designed to target fellowship and help the youth develop as a young man.

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

The program employs a daily shift briefing process to communicate all open alerts and alert updates on youth to staff. In addition, the program utilizes a medical alert log, chronic conditions listing, and master alert board, which is located in the program administration conference room, to ensure staff are aware of youth alerts. Reviewed documentation verified the program's internal alert information is actively reviewed daily, during shift briefings, and by the mental health clinical staff, medical staff and program's supervisory staff. The internal alert board is updated, as needed, by the appropriate staff. The internal alert board contains a photograph of each youth, their Department identification number, age, and colored taps under the information designating each youth's specific alerts. Five staff were interviewed, each staff indicated they received updates on youth's medical, mental health, and security alerts from the alert board in the conference room, as well as through shift briefing. One staff also mentioned receiving medical alerts from the nurses. The facility administrator (FA) interview indicated all alerts are discussed during the morning management meeting and daily shift briefings.

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

The program maintains separate case management, mental health, and medical records for each youth. The case management and mental health records are maintained in a locked record room in the administration area which is clearly identified as "confidential." The medical records are kept in locked cabinets marked as confidential in the locked medical office. The file tab for the youth case management records includes the youth's name, Department identification number, date of birth, county of residence, and committing offense. Each record includes all required sections and is labeled as confidential.

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

The program has a policy and procedures in place which identify a formal method for youth to provide constructive input in the program. The program offers all youth a chance to provide input through monthly surveys which are then compiled, included in the program's monthly Key Performance Indicator report, and shared with staff during the morning management meeting. The program also has a student council which youth must apply and earn their way onto. Documentation confirmed the student council meets bi-weekly and the youth discuss different programmatic issues and any follow-up or changes as a result of their suggestions. The facility administrator confirmed the surveys and student council are a way for the youth to provide input. Five youth were interviewed and four identified student council as a way youth can provide input into program planning, the fifth youth said the youth have input but could not identify a specific method.

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

The program has a policy and procedures in place for the provision of a community advisory board. Sign-in sheets and meeting minutes for the advisory board found meeting were held quarterly during the annual compliance review period. A review of the board's roster found all required members were represented, including multiple judges, law enforcement officers, and parent/guardians of former youth. The only representative not listed on the board roster was from the lesbian/gay/bisexual/transsexual/questioning/intersex (LGBTQI) community; however, the program connected with a representative during the annual compliance review and received a verbal commitment from the representative to attend the next meeting. A review of the group sign-in sheets found three outside members attended in June, three outside members attended in September, and no outside members attended the meeting in December. A review of board documentation found the program sent the notification letters for the upcoming meetings at least six weeks in advance of the meeting. In addition, the program had documentation they sent an e-mail calendar invite to all participants to increase attendance and maintained accompanying responses, including declinations for each meeting. The facility administrator was interviewed and explained the program is currently working to increase participation through additional

efforts, such as the calendar invites. The board has been involved with projects around the program including the addition of farm animals, a hydroponics system, and a game room. A board member was not available during the annual compliance review to interview.

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

The program has a policy and procedures in place to utilize data and stakeholder feedback for program planning. In addition, the policy provides a provision for efforts to decrease turnover and increase employee morale. The program allows staff to provide feedback during monthly surveys which are shared in the program's Key Performance Indicator (KPI) report. The program has a system of staff communication facilitated through daily shift briefings and monthly all-staff meetings. A review of meeting minutes for the all-staff meetings found the administration is sharing the results of the surveys and other data in the KPI reports, results for the Monitoring and Quality Improvement (MQI) report, and other data obtained with staff. Meeting minutes specifically documented action taken as a result of different data, such as a change in signage around the facility after reviewing the results of the program's Trauma Responsive and Caring Environment (TRACE) self-assessment.

The program has an active employee morale committee which meets monthly and discusses different activities and efforts to increase employee morale and decrease staff turnover. Many different events were held throughout the annual compliance review period for staff including a Spades night, employee appreciation lunch and breakfast, bowling night, after work mixer, and Christmas party. The events always included food and prizes such as gift cards, when able, and had large turn outs from staff. Other appreciation efforts, such as a Father's Day gift, were provided to staff. The facility administrator was interviewed and reported the morale committee and monitoring of employee overtime are utilized to increase morale and decrease staff turnover. The program utilizes the KPI report, MQI reports, Comprehensive Accountability Report (CAR), and surveys to assist in program planning. Five staff were interviewed and each reported meetings are held daily and monthly and the information reviewed at these meetings is important and helpful. Four of the staff reported they are briefed on the results of youth and parent surveys while one said only annual compliance reports are reviewed. Three staff reported the communication at the program is fair, one said communication is good, and one said communication is very good. Four staff reported they are provided input into the program through an open-door policy with administration and three reported the employee morale committee provided an opportunity to give input for staff. A review of program vacancies found the program had nine vacancies during the annual compliance review period.

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

The program has a policy and procedures in place outlining the provision for regular staff evaluations, identified as occurring after the first ninety-days of employment and annually thereafter. A review of position descriptions for five pre-service and five in-service staff found each staff received a position description upon hire or promotion with clear performance expectations. A review of evaluations found the evaluations are modeled after the position descriptions to evaluate staff on their performance. Each of the pre-service staff had a ninety-day evaluation and each of the in-service staff had an annual evaluation maintained in their

personnel record. The facility administrator was interviewed and verified staff performance evaluations are completed on an annual basis. Five staff were interviewed and four reported evaluations are completed ninety-days after hire and four reported they are completed annually. A review of the program's vacancies found all key positions are filled, except for the Recreation Therapist, which has been vacant for thirty days. The program provided documentation they are actively recruiting for the position.

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

The program has a policy and procedures which outline the provision of recreation and leisure in the youth programming. A review of the activity schedule found youth are provided with a variety of structured and unstructured recreation and leisure time throughout the week which allow youth to explore areas of interest. A recreation calendar is posted in each living unit for the youth to view. The activities on the calendar are designed to promote social, cognitive, and physical skill development. Recreation is documented in the logbook through the youth movement. If the youth are unable to go outside for recreation, any environmental factors are documented in the logbook. Observations of recreation found youth are offered water during recreation and weather is monitored by staff. Youth are also engaged in physical education programming through the school. The program's contract requires a recreation therapist to assist in the development of recreational programming. The position was vacant at the time of the annual compliance review and had been vacant for thirty days. A review of the education and experience for the previous recreation therapist found the staff met all employment requirements. Documentation found recreation services were still being provided to the youth despite the vacancy by direct care staff, aided by the transition specialist who maintained the recreation calendars during the vacancy. The program has a formal process in place for the youth to provide input in programming, including recreation and leisure opportunities, through the student council. Five youth were interviewed and each reported they receive a variety of recreation and leisure opportunities including basketball, baseball, football, soccer, bowling, boardgames, books, television, and cards. Five staff were interviewed and each reported youth receive at least an hour of recreation daily and are provided opportunities to participate in basketball, football, baseball, soccer, physical contests, indoor bowling, board games, video games, and yoga.

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 in place outlining the program's intake and admission process. A review of five youth case management records indicated each youth's parent/guardian was notified by telephone and in writing of the youth's admission to the program on the day of the youth's arrival. All records contained a letter dated the day of the youth's admission which was sent to the committing court judge, juvenile probation officer (JPO), and post-residential services counselor notifying them of the youth's admission.

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

The program has a policy and procedures in place to ensure each youth is oriented to the program within twenty-four hours of their admission. A review of five youth case management records found each contained documentation the youth were oriented to the program on the day of their admission. All reviewed records contained documentation the youth was oriented to the expectations and responsibilities, behavior management system, daily schedule, access and availability to medical and mental health services, Florida Abuse Hotline numbers, items considered to be contraband, performance planning, anticipated length of stay, dress code and hygiene, procedures for visitation, community access, services, grievance process, emergency procedures, physical design of the facility, treatment team meetings, and assignment of the youth to a living unit. All five youth admissions and intakes were denoted in the program's master control logbook. During the annual compliance review, the annual compliance review team was able to observe the youth admission process and the youth was oriented to the above topics by their assigned case manager on the day of admission. Five youth were interviewed regarding the program's orientation process and all youth indicated orientation to the program started within twenty-four hours of their arrival at the program. All youth further indicated their orientation included the program rules, procedures, and schedule. One youth also indicated they received all the information in the form of a youth handbook and they were introduced to staff.

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

The program has a policy and procedures in place for obtaining written consent of youth who are eighteen years or older for the release of mental health, medical, and substance abuse information. A review of five youth case management records revealed two were applicable for

consent for youth eighteen years or older. The program provided one additional youth record to ensure a minimum sample was reviewed. All three applicable records contained a signed form by the youth which provides the youth's consent for providing or discussing any information regarding the youth's mental health, education and case management to the individuals listed on the form. The forms were either signed on the youth's eighteenth birthday or upon their admission, if they were already eighteen.

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

The program has a policy and procedures in place outlining the program's classification process. The program has an internal alerts board in their conference room which identified each youth's classified risks and it is always accessible to staff. The alert board indicates gang affiliation, security alert, escape risk, medical alerts, and restrictions. A review of five youth case management records revealed all youth had an initial classification meeting which reviewed factors such as the youth's physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization. The classification form also identifies risk factors such as suicide risk, medical risk, escape risk, and security risk. One of the five youth was classified as a suicide risk. Two of the youth were classified as a security risk. None of the five youth were classified as at risk for medical risk or an escape risk. All five initial classification forms indicated the youth were classified for purpose of assigning them to a living area, sleeping room, youth group, therapist, and case manager. The program maintains all risk classification forms in a binder labeled as such.

The program's policy indicates the treatment team completes a new risk assessment on each youth during their monthly formal treatment team meeting. A review of five youth case management records revealed each youth received a risk assessment during their formal treatment team meetings. A review of the five records revealed all re-assessments were completed correctly with no issues. All five youth case management records contained a Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB); however, one of the records indicated the VSAB was completed in the Department's Juvenile Justice Information System (JJIS) three weeks after the youth was assigned to a sleeping room, while all others were done the same day as the youth's room assignment. During the debriefing process, the program acknowledged the VSAB was not entered into JJIS until it was discovered upon records review but was done by paper prior to the youth being assigned to a sleeping room. The program was not able to produce the paper VSAB and indicated they did not know what happened to it. A review JJIS reflected all youth alerts affecting classification were accurate and matched the program's internal alert board. An interview with the facility administrator (FA) indicated the initial classification meeting takes place during the intake

process. In this meeting, factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are considered when choosing housing assignments.

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

The program has a policy and procedures in place outlining the program's process for gang prevention and intervention. The purpose of the program's policy is to prevent and deter the introduction of criminal street gang activity into the program, and to ensure the sharing of gang-related information with the appropriate agencies. A review of five youth case management records indicated two youth were applicable for gang identification and notification to law enforcement. The program provided one additional youth record for review of gang identification and notification. All three applicable records contained documentation local law enforcement was notified, in writing, of each youth's presence in the county and of each youth's gang affiliations. Two of the three records contained written documentation to support each youth's home county sheriff's department and local school district, were notified of the youth's gang affiliation and placement into the program. The third record was a youth who was identified as a gang member prior to arriving at the program and the juvenile probation officer (JPO) had previously informed the youth's home county law enforcement agency of the youth's gang affiliation. The third youth's record also contained notification documentation to the local school board. Two of the three records contained documentation to support each youth's JPO was notified of the youth's gang affiliation and placement in the program. The third record did not require notification to the youth's JPO since they were already aware of the youth's gang affiliations. All reviewed applicable records contained gang alerts entered into the Department's Juvenile Justice Information System (JJIS) as required.

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

The program has a policy and procedures in place outlining the program's process for gang prevention and intervention. The program uses a threat group questionnaire to identify youth as gang affiliated upon their arrival. The program's case manager conducts monthly gang prevention and intervention groups with the youth designated as a gang member, gang associate, or suspected gang member. The program uses the gang curricula 'A New Freedom – Phoenix Resource.' A review of the group sign-in sheets confirms the program has conducted the monthly gang groups for the entire annual compliance review period. A review of five youth case management records confirmed there were two youth who were identified as either a gang member, gang associate, or as having suspected gang affiliations. The program provided one additional record where the youth was designated as having gang affiliations. A review of the three applicable records and group sign-in sheets confirmed the youth have been attending the monthly gang group each month they have been in the program. All three applicable records were reviewed to ensure each youth's performance plan included a relevant goal(s) and/or objective relating to gang intervention strategies for the youth to complete while they are in the program. Each of the youth's performance plan had a gang goal indicating they would

participate in the monthly gang groups. During the program tour, the annual compliance review team did not observe any gang graffiti.

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

The program has a policy and procedures in place for the completion of the Residential Assessment for Youth (RAY) assessments and re-assessments. The policy indicates the program will complete a RAY on each youth within thirty days of admission. A review of five youth case management records indicated all records contained a completed RAY within thirty days of admission. All initial RAY assessments were completed in the Department's Juvenile Justice Information System (JJIS). The program's policy also indicates RAY reassessments will be completed on each youth every ninety days. A review of five youth case management records indicated all records were applicable for one or more RAY reassessments. There was a total of twelve reassessments required in the five records and three of those assessments were completed late by two days. During the debriefing process, the program advised they were relying on the Department's RAY reassessment report which indicates when each youth's reassessment is due for a ninety-day update and the program was able to show the review team the reassessments were completed on the date indicated by the report. The program was unaware the Department's RAY reassessment report does not accurately count the ninety-day timeframe, as it does not account for thirty-one days in a month, which put three of the assessments late by two days. The program advised they will no longer rely on the Department's RAY report and will manually count the due dates. All RAY reassessments were completed in JJIS and a copy was maintained in each youth's case management record.

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

The program has a policy and procedures in place for the completion of the Youth Needs Assessment Summary (YNAS) within thirty days of each youth's admission. A review of five youth case management records indicated all records contained a completed YNAS within thirty days of admission. It should be noted two of the YNASs were not reviewed and marked as completed in the Department's Juvenile Justice Information System (JJIS) database by the director of case management (DCM) which in turn made the YNASs appear to be completed late. The two YNAS assessments were created by the case manager within the appropriate timeframe; however, they were not approved by the DCM within the required thirty-day requirement. All YNAS documents were completed in the Department's JJIS database and a copy was maintained in each youth's case management record.

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 in place for the development of performance plans based on the findings from the initial assessments, and within thirty days of the youth's admission to the program. A review of five youth case management records revealed all performance plans were completed after the completion of the Residential Assessment for Youth (RAY) assessment and Youth Needs Assessment Summary (YNAS) and developed within thirty days of the youth's admission. All reviewed records reflected the youth, treatment team leader, administrative representative, living unit representative, other treatment team members, and educational staff were present for the development of each youth's performance plan. All reviewed performance plans were signed by the youth, treatment team leader, and all parties responsible for goal completion. All performance plans were sent to the youth's parent/guardian; however, there was no documentation in any of the records the parent/guardian signed the plan and returned it to the program.

Each of the reviewed performance plans contained individualized goals based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process. All five performance plans addressed each youth's top three criminogenic needs, and contained specific delinquency interventions with measurable outcomes, which decrease criminogenic risk factors, and promote strengths, skills, and reduce the youth's risk of reoffending. All reviewed performance plans contained a section targeting the youth's court-ordered sanctions; however, only one of the five records reflected the youth had court ordered sanctions to complete. All reviewed performance plans contained transition goals, which were deferred until the youth reached the transition phase of the program. All plans described the youth's responsibilities to accomplish the goals and the program's staff's responsibilities to help the youth complete the goals. All plans contained target dates for goal completion. A copy of all five youth's performance plans were sent to each youth's committing court judge, and parent/guardian within ten days of completion. Five youth were interviewed, and all youth were able to articulate the program's treatment process. All five youth confirmed they received a copy of their performance plan. The interviewed youth indicated they were currently working on anger management, better communication, completing assignments, coping skills, paying attention in school, and their grades. All interviewed youth indicated they discuss their goals at their treatment team meetings.

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

The program has a policy and procedures in place which indicates a youth's performance plan will be modified based on any changes to the youth's Residential Assessment for Youth (RAY) assessment and the youth's demonstrated progress toward completing a goal, and/or lack of progress toward completing a goal. A review of five youth case management records revealed four of the records contained performance plan revisions, the fifth was not applicable for a revision. All four applicable records revealed the youth's performance plans needed modifications based on the youth's RAY reassessments and a change in their needs through demonstration of progress toward goal completion. One record contained revisions based on the youth's lack of progress toward goal completion. None of the applicable records contained performance plan revisions based on newly acquired or revealed information.

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

The program has a policy and procedures in place which addresses the completion of performance summaries and their transmittal. A review of five youth case management records revealed four were applicable for ninety-day performance summaries. The fifth record was not applicable because the date of the youth's initial performance plan had not reached the ninety-day timeframe. All four applicable records contained a performance summary completed ninety days after the completion of the initial performance plan. None of the reviewed records were applicable for performance summaries prior to the youth's release, discharge, or transfer from the program. All summaries contained information regarding the youth's status for each performance plan goal, youth's overall treatment progress, academic status and/or credits, behavior, interaction with peers, interaction with staff, overall behavior adjustment to the program, the youth's level of motivation and readiness to change, and significant positive and negative events. All applicable records contained documentation indicating the youth could read and add comments to their performance summaries. Documentation supported each youth received a copy of their performance summary and the original summary was filed in the youth's case management record. All performance summaries were signed and dated by the treatment team lead, staff member preparing the summary, facility administrator, and the youth. All applicable records contained documentation to support each performance summary was sent to the committing court, juvenile probation officer, youth, and parent/guardian within ten days of completion.

Three closed records were reviewed for discharge and release summaries. All three records contained the original release summary which included the justification for the youth's release from the program. All three applicable records contained a Pre-Release Notification (PRN),

completed forty-five days prior to the youth's release. All summaries and PRNs were signed by the appropriate parties and maintained in the youth's closed case management record. All records contained notification to the parent/guardian confirming the youth's release date once the program received the approved PRN from the committing court. All three records contained a completed exit Residential Assessment for Youth (RAY) assessment. None of the three reviewed closed records were for youth who were considered sexually violent predators and did not require additional discharge documentation or notifications. None of the records required victim notification prior to the youth's release from the program. Interviews with five youth indicated four of the five youth received a copy of their performance summaries and the fifth youth was not applicable for the completion of a performance summary.

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

The program encourages the parent/guardians of each youth to participate in the youth's case management treatment services. At the time of admission, the program mails each parent/guardian an admission letter outlining the case management process and encouraging the parents/guardians to participate in the youth's performance plan and treatment plan process. Attached to the admission letter is a copy of the program's parent handbook, which outlines who will be working with their child, how the program works, treatment and performance team members, medical care, ways of communicating with their child, visitation, program level system, privileges, consequences for negative behaviors, transition planning, assessments, and the grievance process. A review of five youth case management records revealed each youth had regular telephone contact with their parent/guardian. There was also documentation to support the case manager had regular contact with the parent/guardian to update them on the youth's progress in the program. All records also contained documentation to support the parent(s)/guardian(s) were invited to participate in the youth's performance planning and treatment team meetings. The program provided documentation to support they have quarterly family days and letters are mailed to the parents/guardians inviting them to attend, which were seen in the reviewed case management records. An interview with the facility administrator (FA) indicated the youth's parent/guardian(s) are contacted during the youth's intake process and are mailed a parent handbook to help them become familiar with the program rules and procedures. The handbook helps the parent/guardian(s) know what to expect from the program. The FA also indicated each youth's parent/guardian is contacted by the treatment team during their formal meetings to gather input and guidance about the youth.

During the annual compliance review, the review team was able to observe a treatment team meeting. The case manager attempted to reach the youth's parent/guardian(s) by telephone but was unsuccessful. Interviews with five youth indicated they can reach out to their parent/guardian(s) by mail, visitation, and/or telephone. The youth also indicated their parent/guardian(s) are invited to participate in treatment team meetings.

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 in place outlining the required members of each youth's treatment team. The policy further indicates the multi-disciplinary intervention and treatment team shall be comprised of the youth, parent/guardian(s), juvenile probation officer (JPO), representative from the program's administration, representative from the residential living unit, others directly responsible for providing or overseeing provision of intervention and treatment services to the youth, and a representative from education staff who could be present or provide written input. The program has designated the youth's case manager as the leader for each intervention and treatment team to coordinate and oversee the team's efforts. A review of five youth case management records revealed each youth was assigned to a treatment team upon their arrival and each youth's treatment team consisted of the individuals required by the program's policy and Department's administrative rule. All five records contained documentation to support the youth's JPO, and other pertinent parties were invited to participate in each youth's treatment team meeting. All reviewed records contained documentation to support the youth's parent/guardian(s) were invited to participate in each youth's treatment team meeting.

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

The program has a policy and procedures in place for the case management staff to incorporate mental health, substance abuse, and other agencies' performance plans into each youth's performance plan. A review of five youth case management records revealed all youth had mental health and substance abuse treatment plans completed by each youth's therapist. Each of the records contained performance plans which included a goal specifically for the youth to work towards completing treatment services while at the program. All five youth had a safety plan created with the treatment team and each youth's performance plans had a goal indicating the youth would comply with their safety plan. All five youth had a wellness plan completed by the program's recreational therapist and each of the youth's performance plans had a goal specifically for the youth to work towards completion of their wellness plan. None of the five reviewed records contained documentation the youth had individualized academic plans; however, three of the youth's performance plans contained a goal indicating the youth would work towards completion of their education. The program did not have any youth who were involved with the Department of Children and Families (DCF) or the Agency for Persons with Disabilities; therefore, the review team was unable to validate if the program would have incorporated those plans into a youth's performance plan.

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

The program has a policy and procedures in place outlining the program's treatment team meetings, which includes formal and informal meetings. A review of five youth case management records revealed the program invites and encourages active participation from the youth's juvenile probation officer (JPO), and other pertinent members of the treatment team through advance written notification. All five reviewed case management records reflected the youth's parent/guardian received advanced notice of all treatment team meetings. The program notifies the youth's parent/guardian and JPO of each youth's formal treatment team meeting by either telling them during the current treatment team or by putting it on the transmittal letter attached to the performance plan sent out to them from the previous meeting. All five reviewed youth records contained documentation supporting formal treatment teams were held every thirty days. All formal reviews were documented in each youth's case record and included the youth's name, date of review, meeting attendees, comments from treatment team members, a brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress and Residential Assessment for Youth (RAY) assessment results, when necessary. All reviewed formal treatment team meetings indicated a representative from the program's administration, residential living unit, other's directly responsible for service to the youth were present at the treatment team, as well as the educational staff. There was also documentation to support the youth's parent/guardian and JPO were contacted or attempts were made to contact them for their participation in each youth's treatment team meeting by telephone.

All five reviewed records also contained documentation to support, at a minimum, the youth and case manager participated in bi-weekly informal reviews of the youth's performance plan, with one exception. One of the five youth records was missing an informal treatment team for November 2019. During the debriefing process, the program acknowledged the informal treatment team meeting was not completed. All informal performance reviews documented the youth's name, date of review, meeting attendees, comments by other treatment team members, a synopsis of youth's progress in the program, performance plan revisions, progress of goals, positive and negative behaviors, behaviors which resulted in physical interventions, treatment progress and RAY reassessments, when necessary. A review of the Department's Juvenile Justice Information System (JJIS) indicated each youth's anticipated release date was entered into the system and are updated, when necessary, based on the youth's behavior and progress in the program. An interview with five youth indicated they are all provided an opportunity during their treatment team meetings to demonstrate skills they have learned in the program.

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

The program offers Type 3 career education, which requires Florida Career and Professional Education (CAPE) courses leading to pre-apprenticeship certifications and industry certification. The Advanced Manufacturing course was chosen by the Osceola County School District for the

program youth to provide age-appropriate training based upon the length of stay. Youth are assessed for their educational abilities, and career goals. The career education program uses Florida My Career Shines and the Kuder Skills Confidence assessments. Each assessment is used to determine the youth's interests, suggested education, and career options. The program also developed a partnership through a concerted effort with the Waste Pro Services. Waste Pro Services staff come on Saturday mornings to work with the youth. The staff share their experiences and introduces personal accountability skills and modeling behaviors leading to appropriate work habits. Waste Pro Services successfully hired one of the youth from the program. The lead educator and the facility administrator shared during an interview they are also offering aquaponics (fish tank) training, engaging youth in raising chickens and taking care of raised bed gardening, and caring for goats and dogs on the premises which allows youth to receive credit for education and training experience in urban farming and the pet industry.

The education team allows youth to practice completing sample applications online, help with summarizing their education experience in a resume, and adding their career training. Three closed youth records were reviewed and each youth included employability as a goal. Each youth record documented the youth's record included a resume, information for the local Career Source Center, and a Florida identification card. Two of the three youth's exit portfolios had copies of completed sample job applications. During the debriefing process, the program advised the third youth completed sample job applications on-line and the program did not print any applications for the youth's exit portfolio; however, they indicated they would print the applications in the future. Each youth record included an Education Transition Plan which was accompanied by documentation all required parties were notified of the youth's vocational plan.

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 school district has approved a school calendar for the education program which outlines required school hours for the program youth. Youth are required 250 days of education distributed over twelve months; a minimum of twenty-five hours of instruction weekly. There are three two-hour blocks of classes each day. The schedule includes extra minutes built in to provide remediation, therapy groups, and treatment team meetings to ensure no loss of education access. Youth can access General Equivalency Diploma (GED) instruction or tutoring each day. The program's master control logbooks maintained during the annual compliance review period were reviewed and determined the program's daily instructional schedule is taking place consistently. Three separate dates of video in the thirty days prior to the annual compliance review were viewed, which confirmed the youth were transitioned to school early or within five minutes of the scheduled start time. Video review also confirmed the youth exited first period within five minutes of the scheduled release time. Video review further confirmed on the three separate dates educational services were released for the day within five minutes of the time indicated on the program's schedule. Five youth were interviewed and each confirmed there is no interference in educational instruction.

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

Five open youth records and three closed youth records were reviewed for education transition plans. Each record contained an education transition plan which included all required information and was created in collaboration with all required stakeholders. The three closed youth records contained education transition plan which also included appropriate documents essential for the youth to continue their education and vocational goals upon being released. Each youth received a Career Source Center appointment calendar, a valid Florida identification, a birth certificate, a social security card, and transcripts. Two of the three youth's exit portfolios had copies of completed sample job applications. During the debriefing process, the program advised the third youth completed sample job applications on-line and the program did not print any applications for the youth's exit portfolio; however, they indicated they would print the applications in the future. The youth who participated in employability training through the Career and Professional Education (CAPE) programs received certificates, which were maintained in the youth's transition plan. For the closed youth records, the plan documented actions to be taken to assist the youth with their transition and who was responsible. All stakeholders collaborated and were involved in the transition plan process concerning youth education, aftercare, and post-release discharge plans. The school district guidance counselor was involved with the education decision-making concerning educational records to ensure youth can continue education upon release to their zone school or receive post-secondary education support.

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

The program has a policy and procedures in place addressing transition planning, conferences, and Community Re-Entry Team (CRT) meetings. Three closed records were reviewed for compliance with transition planning and CRT meetings. Two of the three reviewed records confirmed each youth had a transition conference completed by the program and held at least sixty days prior to the youth's targeted release date. The third record documented the youth had a transition conference completed by the program; however, the conference was late by twenty-nine days and was conducted thirty-one days prior to the youth's release. During the debriefing process, the program advised the youth originally had a transition meeting set for July 2019; however, the youth's pre-release notification (PRN) was denied by the committing court judge,

which pushed back the youth's release date. The program was then informed by the juvenile probation officer (JPO) the court would release the youth from the program after being in the program for one year. At the time, the program was notified of an acceptable release date from the committing court it was too late for a sixty-day transition meeting; however, the program completed a transition meeting as soon as possible, but it was only forty-five days prior to the youth's projected release date.

All three closed records reflected the youth, treatment team leader, facility administrator or designee, education staff, and other treatment team members attended the transition conference in person. All records reflected the youth's JPO, parent/guardian, and other pertinent parties were invited to the transition conferences; however, if they were unable to attend in person and they participated by telephone, it was denoted on the form. Documentation supported the following information was discussed at each youth's transition conference: transition activities on the youth's performance plan, the performance plan was revised (when necessary), identifying additional transition activities, identify completion dates for goals, and identify person responsible for completion of goals. All transition plans were signed by the treatment team leader, youth, and all other attendees. There was documentation in all closed records to reflect the JPO and parent/guardian received a copy of the youth's transition plan. All three records lacked documentation requesting the individuals who participated in the transition team meeting by telephone sign the transition plan and forward it back to the program. During the debriefing process, the program indicated they would start to request signatures of individuals who participated in the meeting by telephone. All transition meeting information was mailed to the individuals who participated by telephone and there was no interruption of service delivery to the youth, nor was there a lack of sharing of the information.

The three closed records were reviewed for the completion of a CRT meeting prior to the youth's release. All three records contained documentation the youth, and case manager participated in CRT meetings held by each youth's JPO prior to the youth's release. All three youth's CRT meetings were conducted prior to the youth's release and separate from the youth's transition and exit meetings.

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.	

The program has a policy and procedures in place outlining the program's process for the transition of the youth back into the community. The program develops an exit portfolio for all youth during the transitional phase of the program. A review of three closed youth case management records indicated an exit portfolio was discussed and started at or before the youth's transition meeting. A review of the exit portfolios indicated each youth received a state-issued identification card, a copy of their transition plan, social security card, and a calendar with dates, times, and locations of follow-up appointments in their home community. All three exit portfolios contained a copy of the youth's original birth certification, vocation certificates the youth earned in the program, educational documentation, school transcripts, and resume. Two of the three youth's exit portfolios had copies of completed sample job applications. During the debriefing process, the program advised the third youth completed sample job applications on-line and the program did not print any applications for the youth's exit portfolio; however, they indicated they would print the applications in the future. There was documentation in the educational transition plan record in the Department's Juvenile Justice Information System (JJIS) each of the three youth's educational records were forwarded to their home counties

school district. There was documentation in all three closed records the youth's exit portfolio was verified and discussed during the exit conference. Documentation in all three records supported each youth received a copy of their exit portfolio upon their release. There was also documentation in all records indicating the case manager sent the entire case management record, along with a copy of the youth's exit portfolio, to the youth's juvenile probation officer.

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

The program has a policy and procedures in place outlining the program's exit process. A review of three closed youth case management records revealed all three youth had an exit conference held after the youth's juvenile probation officer (JPO) was notified of the youth's release date and at least fourteen days prior to the youth's release. All three records contained the program's exit conference form with the date of the conference, signatures of participants, and a summary of the youth's pending transition goals. All exit conference forms indicated the team discussed the youth's transition activities established at the transition conference and finalized the plan for the youth's release. All exit conference forms were signed by the youth, education representative, treatment team leader, transitional services manager, and therapist. All three exit conference forms were either signed by the parent/guardian(s) and JPO or it was denoted they participated in the conference by telephone. A review of the Department's Juvenile Justice Information System (JJIS) database reflected the date of the youth's admission and release date from the program was accurate.

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 full-time licensed mental health counselor (LMHC) serving as the designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the State of Florida, with an expiration date of March 31, 2021. The DMHCA is on-site a minimum of five days a week, for a total of forty hours. The DMHCA is on-call twenty-four hours a day, seven days a week and is responsible for the coordination and implementation of mental health, substance abuse, and specialized services at the program. The DMHCA has a back-up licensed mental health counselor (LMHC) who covers when the DMHCA is on leave and works twenty-five hours weekly at the program. The program provides services to youth who have been diagnosed with Borderline Developmentally Disabled/Developmentally Disabled (BDD/DD). The DMHCA ensures clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. An interview with the DMHCA and review of the position description validated they are on-site a minimum of forty-hours weekly to coordinate all mental health services, review and sign weekly progress notes, conduct treatment planning, assessments of suicide risk (ASR), follow-up ASRs, and quarterly reviews of treatment records.

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 in place addressing the program's contractual requirement to have at least one licensed professional on-site five days a week. The program has one full-time licensed mental health clinician (LMHC) who is the designated mental health clinician authority (DMHCA) and one part-time LMHC. Both LMHCs have a clear and active license in the State of Florida, with expiration dates of March 31, 2021. The program also contracts with a licensed psychiatrist who was found to have a clear and active in the State of Florida which an expiration date of January 31, 2022.

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 a policy and procedures in place indicating licensed mental health staff shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The policy further indicates all non-licensed staff shall receive direct supervision from a licensed professional on a weekly basis and master's-level staff who perform Assessments of Suicide Risk (ASR) shall have twenty-hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The program holds a Chapter 397 licensed to provide substance abuse services to the youth in the program, which expires April 1, 2020. The program has five non-licensed clinicians who provide regular mental health and substance abuse services to the youth in the program. A review of each clinician's personnel record revealed each is a master's-level therapist with a degree and coursework in the appropriate discipline. The only staff who completed ASRs during the annual compliance review period were the designated mental health clinician authority (DMHCA) and the part-time licensed mental health clinician (LMHC). One of the non-licensed clinicians is currently in training to be able to complete ASRs.

A review of the program's clinical supervision binder for the annual compliance review period indicated all five non-licensed clinicians received weekly supervision, when they provided services to the youth, from the DMHCA, who is a LMHC, except for one week with one non-licensed clinician. Documentation was provided indicating the clinician was hospitalized the night before the weekly supervision meeting and was out of work for the rest of the week. Weekly documentation included the date the supervision was held, time and hours the supervision was provided, names of clinicians in attendance, signatures of the attendees, and the signature of the licensed professional who provided the supervision. The weekly supervision documentation also contained a summary of the supervision sessions, instructions and directions to the clinicians, and a review of sample treatment or summary notes.

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

The program has a policy and procedures regarding the provision of a mental health and substance abuse screening upon admission. Five mental health and substance abuse youth records were reviewed for documentation of a comprehensive screening process and each record 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. Documentation confirmed 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 prior to completion of the MAYSI-2. The review was documented on the Commitment Packet Review

Checklist and facility administrator, clinical director, education coordinator, and nurse also reviewed the packet prior to, or on the day of the youth's admission. Each of the five youth were referred for an Assessment of Suicide Risk (ASR) and comprehensive assessment regardless of screening results; however, in the event a MAYSI-2 indicates a need for further assessment, it is documented and followed-up on all assessments. Each of the five records contained an ASR which was completed the day of admission by a licensed professional and signed off by the designated mental health clinical authority (DMHCA) and facility administrator. All five records contained an examination by a licensed professional to assess mental health and substances abuse needs on the day of admission. All five reviewed youth records contained a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment. Each of the five youth records also contained a Brief Behavioral Health Evaluation completed by the DMHCA, or a therapist, regardless of the results of the MAYSI-2.

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.	

Five open mental health and substance abuse records were reviewed and each contained a new, combined comprehensive mental health and substance abuse evaluation, which included all required information, within thirty days of admission. Each evaluation was completed by a licensed mental health clinician or a non-licensed master's-level clinician and approved by the designated mental health clinical authority (DMHCA) within the required timeframe. None of the youth received an updated assessment for this review. In addition to the evaluation, all youth received a Youth Outcomes Survey (YOQ) to assess clinically significant mental health and substance abuse needs/risks by tracking actual change in functioning for the Borderline Developmentally Disabled/Developmentally Disabled (BDD/DD) population.

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.*	

Five mental health and substance abuse records were reviewed for mental health and substance abuse treatment. All five 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, program operations staff, as well as a representative from medical. The treatment team assignments were updated, when needed, if any changes occurred. The treatment team is responsible for developing, reviewing, and updating the youth's individualized mental health/substance abuse (MH/SA) treatment plan and discharge treatment planning. All five records included a signed Substance Abuse Consent and Release forms. Each of the five reviewed records included a MH/SA initial treatment plan implemented the day of admission and an individualized MH/SA treatment plan completed within thirty days of admission. Three of the youth records had a current Authority for Evaluation and Treatment form (AET) while the other two contained a Consent for Release of Information for youth over

the age of eighteen, as required. Each youth received individual, group, and family therapy, psychoeducational training, medical/psychiatric services and individual substance abuse treatment as indicated on their individualized MH/SA treatment plan. All clinical interventions were documented on mental MH/SA treatment progress notes. The program documented their notes on the Department form containing all the information required.

A review of group sign-in sheets found all groups contained the appropriate number of youth, eight or less, as outlined in the program's contract. A group was observed during the annual compliance review and was found to follow the prescribed curriculum provided to the review team. A treatment team was able to be observed during the annual compliance review and confirmed the youth are assigned to a treatment team and during the meetings review their progress in the program, including progress on the MH/SA treatment plan. The designated mental health clinical authority (DMHCA) confirmed the treatment services provided to youth. Five staff were interviewed and each reported only therapists 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.*	

Five open mental health and substance abuse (MH/SA) youth records were reviewed for treatment planning. All five records contained an initial treatment plan completed the day of admission. These plans were signed by the treatment team and the designated mental health clinical authority (DMHCA) on the day of admission. The initial treatment plans included all required elements. Each of the five records contained an individualized formal MH/SA treatment plan which was completed within thirty days of admission. Each youth's plan was signed by each member of the treatment team on the day of creation and the plan contained all required elements including the youth's diagnosis, a description of symptoms, measurable and achievable goals and a list of services prescribed. Each service prescribed to the youth was outlined with the amount, frequency, and duration of the service. All plans were approved by the DMHCA within the required timeframe. Two youth were admitted with psychotropic medications and the initial treatment plans and individual treatment plans addressed the provision of psychiatric services and medication monitoring. Both youth were seen by the psychiatrist within the youth's first fourteen days at the program and an initial diagnostic interview completed. Three youth were prescribed or continued on medications while in the program and each had an explanation for the needs for the medication. Each of the five reviewed youth records had a monthly treatment team review which addressed the youth's progress toward meeting each of the identified treatment goals and objectives and identified the youth's continued need for services.

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 and a copy was given to all required parties to include the parent/guardian, juvenile probation officer (JPO), and judge. There were no youth released from the program actively on suicide risk or suicide precautions, requiring a notification to the parent/guardian or JPO.

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

A review of the program's contract and clinical program description indicated services are available through the provision of Borderline Developmental Disability/Developmental Disability services (BDD/DD). Each youth in the program has been diagnosed as BDD/DD prior to admission. The program's specialized treatment services are designed to address the youth's mental health and substance abuse needs, as well as their cognitive functioning. 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. In addition, the program contracts with a psychologist and a Certified Behavior Analyst who conduct behavioral assessments and work with youth as needed to address specific behavioral issues. The BDD/DD program maintains a ratio of one-to-ten on the clinician caseloads. The program also contracts with a State of Florida board-certified licensed psychiatrist who provides bi-weekly on-site services.

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

The program maintains an agreement with a psychiatrist practicing child and adolescent psychiatry. The reviewed license showed the program's psychiatrist carries a clear and active medical doctor (MD) license with an expiration date of January 31, 2022. A review of the psychiatric visitor log confirmed the psychiatrist has been on-site at least bi-weekly 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. Five youth records were reviewed, and three records showed youth were prescribed or continued on psychotropic medications while enrolled in the program. The program practice is to refer all youth for an initial psychiatric evaluation, regardless of medication status and each of the five records demonstrated the psychiatric initial diagnostic interview was completed within fourteen days of admission. Each diagnostic interview included all required information. 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 of the three youth prescribed psychotropic medications received medication reviews at least every thirty days. An interview with the program's psychiatrist confirmed the psychiatrist's role of bi-weekly on-site services, providing initial psychiatric evaluations for every youth entering the program,

providing medication management for all youth on psychotropic medications, and emergency consultation, as needed. The psychiatrist meets with the designated mental health clinician authority (DMHCA) each time they are on-site to review youth and provide input into treatment plans to be shared with each youth's treatment team. The program does not employ an advanced registered nurse practitioner for psychiatric services.

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 policy and procedures and maintains a comprehensive plan for mental health and substance abuse (MHSA) services which includes suicide prevention procedures. The MHSA plan was last updated and approved by the facility administrator (FA) and the designated mental health clinician authority (DMHCA) on January 13, 2020. The program's plan detailed suicide prevention procedures and included all required elements. The plan included but was not limited to: identification and assessment of youth at risk of suicide, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and the review process. The plan addressed the requirements for staff training as it relates to suicide prevention, the implementation of suicide precautions, and recognizing verbal and behavioral cues. Additionally, regardless of screening results, each youth receives a comprehensive evaluation within thirty days of admission. An interview with the facility administrator indicated the program provides suicide prevention training throughout the year and conducts quarterly mock emergency mental health drills to include emergency response to suicide attempts or self-inflicted injury.

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 screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The plan includes the provision of review by program administration of any serious incidents of self-harm. The program maintains a suicide response kit located in the master control area. A program tour during the annual compliance review confirmed each kit contained the knife-for-life, wire cutters, and needle nose pliers. A review of five 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. The assessments were all completed by a licensed professional or someone who was under the supervision of the licensed professional. Four of the five ASRs determined the youth were not at risk of suicide and the youth were placed on standard supervision. The fifth youth was placed on

precautionary observation (PO) based on the admission ASR. There were two additional youth records reviewed for youth placed on PO, each of which was the result of the admission ASR. While on PO, program staff maintained Suicide Precautions Observation Logs and documented supervision was conducted as required. Follow-up ASRs were completed for each youth prior to removal from PO. The designated mental health clinician authority (DMHCA) and facility administrator, or designee, documented their communication prior to stepping down the youth's level of supervision. The program's logbooks contained documentation of when youth were placed on PO and when they were stepped down to less restrictive supervision. Youth placed on PO 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 by mental health staff. All ASRs completed during the annual compliance review period were completed by the DMHCA or the program's other licensed clinician. There were no non-licensed therapists who completed ASRs reviewed during the annual compliance review period. The program did not have any secure observations; however, there is a policy and procedures in place for the use of secure observation rooms if needed. Five staff were interviewed and each reported when a youth expresses suicidal thoughts, direct care staff are responsible for notifying mental health and placing the youth on PO with constant sight and sound supervision.

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

Five youth mental health records were reviewed, one of which was applicable for placement on precautionary observation (PO). Two additional records were provided for review of maintenance of PO logs. 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. Each PO log documentation supervision was maintained as required, which included checks of the youth at no more than thirty-minute intervals and were found to be in real-time. Observations of the youth's behavior were documented and any warning signs which required follow-up were documented on the back of the form and discussed with mental health staff. Each shift supervisor and mental health staff signed the logs daily. Two of the youth reviewed for placement on PO were interviewed, the third youth was unable to be interviewed due to being discharged from the program. Both youth indicated staff never left the youth for any period of time while the youth were on PO.

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

The program has a policy and procedures to ensure all staff who work with youth shall receive six hours of suicide prevention training to include: recognition of verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions. Five in-service staff training records and five pre-service training records were reviewed for required suicide prevention training. All ten reviewed records contained a minimum of two hours of the Department's Learning Management System (SkillPro) training and four hours of instructor-led training. Mock suicide and mental health emergency drills were reviewed for the last four

quarters (January 2019-January 2020) and a drill was conducted on each shift in all quarters. The program conducted a total of thirty-one drills during this timeframe. Drill participation was reviewed for twenty-three direct care staff, and the results show all twenty-three staff participated in at least one quarterly mental health drill semi-annually. Staff participate in mock suicide and mental health emergency drills. All staff reviewed had documentation of participation in a mock suicide drill which contained the use of cardiopulmonary resuscitation (CPR), first-aid, and the use of a suicide response kit. The drills detailed all participant roles during the drill and detailed the methods for contacting other program staff, the Central Communications Center (CCC), medical and mental health personnel, and emergency medical services. An interview with the facility administrator confirmed mock suicide and mental health emergency drills are conducted at a minimum of once a quarter for all staff on all shifts. Five staff were interviewed about various drills they have participated in and all staff indicated they had participated in medical and mental health drills quarterly.

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 policy and procedures in place to respond to youth in crisis in the least restrictive method possible to protect the safety of the youth and others while maintaining control and safety of the facility. The program maintains a crisis intervention plan. 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 plan was approved annually and last approved by the designated mental health clinician authority (DMHCA) and facility administrator on January 13, 2020.

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

Five 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 which 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 an emergency mental health and substance abuse plan. The plan contains, all required elements including: immediate staff response, notifications, communications, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance assessment and treatment, documentation, training (including mock drills), and review. The plan was approved annually and last approved by the designated mental health clinical authority (DMHCA) and facility administrator on January 13, 2020.

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

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

Standard 4: Health Services

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

The program has a facility operating procedures (FOPs) which indicates the program shall contract with a designated health authority (DHA) with the appropriate training and knowledge to be accountable for ensuring the delivery of administrative, managerial, and medical oversight of the facility healthcare system. The DHA shall be clinically responsible for the medical care of all facility youth. The program has a contract with a licensed physician who holds an unrestricted license in the State of Florida with an expiration date of January 31, 2021 and had specialty training in internal medicine. During the annual compliance review period, the program had a backup DHA to provide coverage in the event the DHA was not available who also holds an unrestricted medical doctor license in the State of Florida. In December 2019, the back-up DHA resigned and at this time there is no back-up in the event the DHA is unavailable; however, services have been delivered as required. A review of the sign-in logs for the annual compliance review period indicated the DHA was on-site at least once a week; two of the weeks the DHA was on-site ten days apart instead of the maximum of nine days. The DHA interview indicated their role at the program is to complete Comprehensive Physical Assessments (CPA) within seven days of admission, complete periodic evaluations, conduct sick calls requiring follow up, involved in policy and procedure development, and provide on-call services twenty-four hours a day seven days a week, including holidays.

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 facility operating procedures (FOPs) which outlines the program's healthcare services. The designated health authority (DHA) and the facility administrator (FA) signed and dated all respective treatment protocols and FOPs on an annual basis. The DHA also wrote and approved all treatment protocols and standing orders. The psychiatrist reviewed and signed the FOPs related to psychiatric services. The nursing staff signed and dated a cover page on which all FOPs and treatment protocols were listed to acknowledge their annual review. The program had one newly employed healthcare staff since the last annual compliance review and a review of the registered nurse (RN) comprehensive clinical orientation training indicated the staff member's orientation included all Department's healthcare policies and procedures, as required.

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

Five youth individual healthcare records (IHCRs) were reviewed and contained a legible copy of the Authority for Evaluation and Treatment (AET) with the word "copy" stamped on the form. All AETs were valid for as long as the youth was under the supervision of the Department. In two IHCRs, the youth turned eighteen years of age while in the program and the staff had the youth sign a consent for youth eighteen years or older. The program did not have any youth in the care of the Department of Children and Families (DCF). In four of the five IHCRs, the completed

parental notifications were maintained behind the AET in each IHCR. In one IHCR, the youth turned eighteen years of age two days after admission and no parental notifications were completed. The nursing staff interview indicated, the program's policy for obtaining a new or current AET is to send a request for parent/guardian signature to the parent/guardian or juvenile probation officer (JPO) to obtain signatures and to receive medical treatment. For youth who are eighteen years of age or older, the program has a consent for the youth to sign.

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

Five youth individual healthcare records (IHCRs) were reviewed for parental notifications including over-the-counter medications and vaccinations/immunizations not consented for on the Authority for Evaluation and Treatment (AET), significant changes to existing medications, off-site emergency care and medical treatment, discontinuation of medication prescribed prior to youth entering the custody of the Department, and for new medications. Four of the five IHCRs were applicable for written notifications being sent regardless of telephone notifications. For all telephone notifications, a second staff member witnessed all telephone call attempts and conversations. One youth psychotropic medication drug dosage was changed and parent/guardian verbal consent was documented on the Clinical Psychotropic Progress Note (CPPN), as well as written consent being documented on the Acknowledgment of Receipt of the CPPN. In all five IHCRs, the vaccinations were verified within thirty days of the youth's admission. There were none applicable regarding religious or medical exemption. The nursing staff interview indicated immunizations are obtained from the Department's Juvenile Justice Information System (JJIS) or Florida Shots and they are reviewed during the admission process. There were no youth in the program in the custody of the Department of Children and Families (DCF).

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

Five youth individual healthcare records (IHCRs) were reviewed and all five contained a Facility Entry Physical Health Screening (FEPHS) form completed on the date of admission by a registered nurse (RN). In two IHCRs, the youth had a change in physical custody while in the program, one had four separate occasions, and the remaining youth had one change in custody. Each time the youth returned to the program, a new FEPHS was completed on the date of return by an RN. An interview with the RN confirmed the practice for completing FEHPS forms at admission and re-admission to the program.

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

Five youth individual healthcare records (IHCRs) were reviewed and all five received a general care orientation upon admission to the program which included the topics of 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. All of the orientation topics were documented on the Department's form for healthcare education. A review of the healthcare contacts found the contacts are accurate.

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

Five youth individual healthcare records (IHCRs) were reviewed and one was applicable regarding admission with a known or suspected chronic condition. The program was only able to provide one additional example of youth entering the program with a chronic condition during the annual compliance review period. In the two applicable records, the youth were admitted with a known chronic condition and there was evidence in the IHCR a referral was made to the designated health authority (DHA) telephonically. None of the youth were admitted to the program requiring an emergency response or notification to the DHA.

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

Five youth individual healthcare records (IHCRs) were reviewed and each contained a new Health-Related History (HRH) form which was completed by a registered nurse (RN) within seven days of admission. In the five reviewed IHCRs, the HRH was completed before or at the same time as the Comprehensive Physical Assessment (CPA) and the designated health authority (DHA) documented review of the HRH on the CPA by marking the checkbox. The nursing staff interview indicated the RN is responsible for completing the HRH on the day of each youth admission.

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

The program has a facility operating procedures (FOPs) which outlines the requirements for completing the Comprehensive Physical Assessment (CPA) and is written in compliance with the Centers for Disease Control and Prevention new 2006 recommendations and the Occupational Safety and Health Administration (OSHA) standards which includes procedures for tuberculosis screening. Five youth individual healthcare records (IHCRs) were reviewed. The program utilized the Department's CPA form. In all five IHCRs, the CPA was completed within the first seven days of the youth's admission by the designated health authority (DHA) and the

medical grade was documented on the form. All five CPAs were completed in accordance with the Department's rule requirements and all sections were marked with an "O" or an "X". Any section of the exam which was refused was marked appropriately and "youth refused" was documented with the youth's signature next to the statement. The Department's Problem List was updated if necessary. At least one tuberculosis skin test (TST) was documented in each IHCR, which was completed within the last year and the results were documented on the CPA and the Infectious and Communicable Disease (ICD) form. All five youth were assessed prior to placement in the general population. The nursing staff interview indicated a new CPA is being completed by the DHA within seven days of the youth's admission and annually, thereafter.

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

Five youth individual healthcare records (IHCRs) were reviewed and all youth were screened and evaluated for sexually transmitted infections (STIs). Three IHCRs needed further evaluation and the youth was referred to the designated health authority (DHA). All three applicable youth received testing on the date of admission and the results were documented on the Infectious and Communicable Disease (ICD) form, excluding the human immunodeficiency virus (HIV) results. The referrals as well as the testing were documented on the STI form and/or the progress notes. In all five IHCRs, the youth was offered HIV counseling and testing but only three youth consented and received the HIV test. Consent was maintained in the IHCR. The HIV test results were filed in a confidential manner consistent with the Florida Statute in a sealed envelope marked "Confidential" and were not included in the program's internal alerts. The HIV counseling and testing was provided by an outside source who has the 500/501 certification from the Department of Health (DOH). Five youth were interviewed and each indicated they could ask for an HIV test if they wanted one.

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

The program has a facility operating procedures (FOPs) which outlines the provision of sick call included procedures for when licensed healthcare staff are not on-site. Five youth individual healthcare records (IHCRs) were reviewed and none of the youth presented with similar sick call complaints three or more times within a two-week period or complained of any severe pain with which the staff was unfamiliar. Three of the five youth completed Sick Call Request forms which were placed in a locked box and retrieved by the nursing staff. In the three applicable records, the nurse completed the Sick Call Request form and filed them with the progress notes in the IHCR in reverse chronological order. One of the youth had been on controlled observation on several occasions and was questioned daily for sick call and/or health complaints which was documented in the IHCR. In the three applicable records, the Sick Call Request Form or progress notes were documented in accordance with the Health Services Rule and each sick call was also documented on the Sick Call Index and the Sick Call Referral Log. The program conducts sick call daily as indicated in their contract and the hours are posted in each of the youth's modules. Sick call is conducted by a licensed nurse. One sick call was observed with

the verbal consent of the youth. The youth was escorted by a youth care worker to the clinic where the youth sat on the exam table in view of the youth care worker. The youth care worker remained outside of the exam room to maintain confidentiality. There were no other youth present. The nurse indicated the reason why the youth was being seen as it was written on the Sick Call Request Form and began to question and examine the youth, including taking the youth's vitals. After the examination was concluded, the youth was given a follow-up plan, and a Sick Call Request form to sign. Five staff were interviewed and each indicated the nurse conducts sick call. Three of the five interviewed indicated they can see a nurse within one day of requesting sick call and two stated they can be seen within three days.

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

The program has a facility operating procedures (FOPs) outlining the provisions of episodic, first aid, and emergency care which includes the monitoring of first aid kits and emergency medical services being available twenty-four hours a day seven days a week. Five youth individual healthcare records (IHCRs) were reviewed and none required on-site first aid or episodic care. The program was able to only provide one additional record for youth having received on-site first aid or episodic care. In the one applicable record, the youth received on-site care by a licensed healthcare staff which was documented in problem oriented subjective, observation, assessment, and plan (SOAP) or standard narrative charting on three separate occasions. The events were documented on the Episodic Care Log.

The emergency numbers were posted within the clinic in the nurse office which is inaccessible to the youth. The program has six first aid kits; two used for transportation, one located in the kitchen, one in each of the two sub control rooms, and one in the master control room. A review of three first aid kits to include the two for transportation, indicated the contents were approved by the designated health authority (DHA) and were fully stocked with the required materials. The nurses monitors the first aid kits monthly and will replenish the contents when needed. The program has two suicide response kits, one in each of the sub control rooms and each included all required items. The program also has one automated external defibrillator (AED) which was located in the staff break room and had the instructional binder behind it. The medical staff checked the AED during the annual compliance review and it was in working order. The last six months of AED documentation indicated the nurses conducted weekly checks. The AED pads expires on May 31, 2020 and the battery expires on November 30, 2021. A review of the last three quarters of medical drills was conducted and indicated the program completed at least one quarterly drill on each shift to include first aid care, as well as conducting cardiopulmonary resuscitation (CPR) and/or AED demonstration annually. Five pre-service and five in-service training records were reviewed and indicated each staff had the CPR, AED, first aid, and epinephrine auto-injector training. A current CPR with AED certification was found for all licensed healthcare staff. Five staff were interviewed and indicated they are permitted to call 9-1-1 when a youth is identified with a medical emergency.

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

Five youth individual healthcare records (IHCRs) were reviewed and two were applicable regarding off-site care events. The program provided an additional record for a total of three applicable records. In the three applicable IHCRs, the youth required off-site first aid or emergency care and parental notifications were made. The Summary of Off-Site Care form was utilized to document each event and was filed in each IHCR, as well as the discharge instructions. In all three IHCRs, the designated health authority (DHA) reviewed and signed all off-site care findings, instructions, and information. All three youth received the required follow-up testing, referral, and care as appropriate.

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

Five youth individual healthcare records (IHCRs) were reviewed and two were applicable regarding a chronic condition. The program provided one additional IHCR. In the three applicable records, only one documented the youth's chronic condition on the Facility Entry Physical Health Screening form. The remainingtwo were diagnosed after seeing the designated health authority (DHA). Two youth were undergoing treatment for a physical health condition with a Body Mass Index of greater than 30 and the third youth was suffering from migraines. All three were classified with medical grade two through five, placed on the chronic illness list, received a specialized treatment plan, and the evaluations were tracked. Two received periodic evaluations at no greater than three months intervals. The remaining youth was not yet due for a periodic evaluation. The periodic evaluations were documented and maintained in each IHCR chronological progress notes and there was no indication of lapses in care. In all three records, the Department's Problem List was updated in accordance with the Health Services Rule. The facility administrator (FA) interview indicated important medical issues are discussed daily at the morning meeting and all youth are seen weekly by the DHA and are discussed with the FA. The nursing staff interview indicated the DHA is notified at the time of admission by the RN for youth admitted with serious or chronic conditions. The DHA interview indicated every ninety days or less, periodic evaluations are conducted for youth with chronic conditions and dates for evaluations are tracked on a daily medical alert log.

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

The program has a facility operating procedures (FOPs) outlining the requirements for medication management and includes the process for disposal of unused medication. Five youth individual healthcare records (IHCRs) were reviewed and two youth were admitted with medications. The program provided one additional example. The three applicable IHCRs indicated the youth were taking medications at the time of admission and were verified prior to the youth being accepted into the program. The Department's Prescription Medication

Verification Checklist was utilized. In all three IHCRs, the designated health authority (DHA) and the designated mental health authority (DMHCA) were notified and instructed the medical staff to continue the prescribed medication as indicated. In all three IHCRs, the medications were given pursuant to a current, valid order/prescription and the standard Department Medication Administration Record (MAR) was utilized to document all medication and treatment. Each MAR clearly indicated medication start and stop dates and staff initialed each medication entry as well as documented weekly side effect monitoring. In the three applicable IHCRs, the DHA placed an order on the Practitioner Order Form when a current medication was continued, discontinued, changed, or a new one was ordered. In two of the three applicable records, the youth refused to take the medication and the refusal was documented on the refusal form, as well as the MAR. The Six Rights of Medication Delivery was maintained by the staff.

The program's clinic was observed. All medications were stored in separate locked areas inaccessible to youth. The medication cart was clean and well organized having separate compartments for oral, injectable, topical, liquids, and controlled medications. The program maintains non-controlled medication and sharps/syringes in the locked medication cart in a locked room, as well as behind locked cabinets and in locked drawers in the clinic. All controlled medications are stored in the locked medication cart in a separate locked box. The program has a small locked refrigerator which is utilized for youth medications requiring refrigeration. The program had only one medication which was stored in the refrigerator at the time of the annual compliance review.

Medication pass for four youth was observed during the annual compliance review. The medication pass was conducted in the sub control room wherein the nurse was inside the control room door and had the medication cart as a barrier between the nurse and the youth. The medication cart was observed to be clean and organized. All medications were in pill packs with controlled medications being in a separate locked box in the cart. The nurse verified the Six Rights of Medication Administration with each youth, provided the medication without pre-pouring, and checked each youth's mouth after they had taken the medication. The nurse immediately filled out the Medication Administration Record (MAR) and conducted the side effect monitoring. Two of the youth received a controlled medication was observed for controlled medications by the direct care staff who is also trained is assisting youth with medications swabbed the youth's mouth and conducted a shift-to-shift count on the inventory with the nurse. One youth refused the medication; however, after the nurse counseled the youth, the youth took the medication.

The nursing staff interview indicated the medication inventory is locked and perpetual and weekly inventories are maintained. The program's practice is to secure controlled substances such as narcotics using double locks on the medication cart. Medications are destroyed by two nurses and the program has a contract with a consultant pharmacist who comes on a monthly basis for monitoring. Five youth interviews indicated three did not take any medications. One youth stated when medication is provided, the nurse will ask the youth to state their name, provide the youth with the medicine, the youth drinks water, and the youth mouth is swabbed to check if the medication was taken. The remaining youth stated during medication pass, the youth approaches the medication cart, sign for their medication, given water, and the nurse checks the youth mouth to see if the medications were taken.

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

The program has a facility operating procedures (FOPs) for medication management which includes the process for disposal of unused medication. The FOPs further specifies unused medications shall be returned to the pharmacy on a monthly basis, 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, and needles, syringes, and other disposable medical equipment and supplies shall be properly disposed of at least once a month. The FOPs also indicated if the 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 program director before the off-going shift is released from duty. This process was verified through an interview with nursing staff.

The program's clinic was observed. All medications were stored in separate locked areas inaccessible to youth. The medication cart was clean and well organized having separate compartments for oral, injectable, topical, liquids, and controlled medications. The program maintains non-controlled medication and sharps/syringes in the locked medication cart in a locked room, as well as behind locked cabinets and in locked drawers in the clinic. All controlled medications are stored in the locked medication cart in a separate locked box. The program has a small locked refrigerator which is used for youth medications requiring refrigeration. The program had only one medication which was stored in the refrigerator at the time of the annual compliance review.

The last six months of inventories of all sharps and over-the-counter (OTC) medications were reviewed. Perpetual and weekly counts were conducted. In the five records reviewed, the controlled substance shift-to-shift inventory was documented on the Individualized Controlled Medication Inventory Record as well as the remaining pills/tablets after each administered dosage for all other prescribed medications. Two youth medications, including a controlled medication, three OTC medications, and three sharps were inventoried by the review team. In addition, the nurse was observed conducting a shift-to-shift count of controlled medications during medication pass and counting medications in the clinic. All were verified to be accurate. The program has a list of staff which are trained in the assistance to self-administration of medication when nursing staff are not on-site. The nursing staff interview indicated the medication inventory is locked and perpetual and weekly inventories are maintained as well as their practice to secure controlled substances, such as narcotics by using double locks on the medication cart.

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

The program has an infection control procedure in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, written in accordance with the Occupational Safety Health Administration (OSHA) federal regulations and the Center for Disease Control (CDC) guidelines. The procedures include common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, Tuberculosis, Hepatitis A, B, and C, as well as human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. Other outbreaks or epidemics caused by any other infectious agent whether spread directly or indirectly, outbreaks of pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms are included as well as food-borne illnesses, bio-terrorist agents, chemical exposures in the workplace, providing Hepatitis B immunizations for staff, staff having access to protective equipment, staff following standard universal precautions and a comprehensive process for needle stick post-exposure evaluation. The facility administrator (FA) will establish a separate file containing all documents for youth and staff if they have experienced a facility/occupational exposure. The program did not have any instances in which the local county health department, CDC and/or the Department's Central Communications Center (CCC) had to be notified regarding infectious diseases, any quarantining, or hospitalization. The program's exposure control plan is combined with the infection control procedure and is available to all staff. The plan was reviewed and signed annually by the administration of the program and included risk assessment and methods of compliance. In all five records reviewed, each youth received training to include the prevention of blood borne pathogens and communicable disease. A review of the five pre-service training records indicated all received the infection control and exposure control training. The FA interview indicated the exposure control plan is located in the clinic.

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures establishing how they will maintain active supervision of youth at all times. Observations during the annual compliance review found the program was following their posted schedule. Staff were seen providing appropriate supervision while the youth were in class, in their rooms on break, during meal times, in groups, during recreation, and during sleeping hours. Staff exercised appropriate positioning and maintain youth within sight at all times. Throughout all observations during the annual compliance review, the staff to youth ratio of one to six was maintained as required. The review team observed one exception with youth supervision the last day of the review. Two staff were moving a group of youth from their living module to a classroom. The staff called their movement into master control and were almost off the living unit when a youth banged on their door from the far end of the hallway on the module. A review of the master control logbook found a discrepancy with the number of youth reported in the movement. The program immediately conducted training with master control staff to ensure they identify any variances from the number of youth who should be on a given living module. Informal interviews with two staff found they knew the number of youth under their supervision immediately without having to stop and count. Formal interviews were conducted with five staff. The staff consistently indicated all movement would stop and they would immediately conduct a recount if the count is not correct. Three staff indicated all youth would be locked down and they would continue to conduct counts until they could clear the discrepancy.

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

The program has a policy and procedures addressing the implementation and training of the program's behavioral management system (BMS) which was revised by the facility administrator (FA) on August 1, 2018. There were no changes to the BMS since the last annual compliance review. The program has a clearly written BMS which is a multi-level system designed to enhance the youth treatment, increase healthy relationships, pro-social behavior using reinforcing, and decreasing unhealthy behaviors through natural consequences. If youth are unable to be redirected from their problem behavior, a Problem Behavior Report (PBR) would be completed and youth would lose points for the hour block of time. A review of five staff training records for pre-service training and five staff training records for in-service training, indicated staff were trained on the BMS. The program has an agreement with the Osceola County School District related to the BMS and verified teachers are trained in the

implementation of the BMS. Youth are made aware of the BMS during orientation. Each youth is provided a program handbook which describes the BMS. A review of five youth records indicated each received an orientation informing the youth of the BMS which includes youth expectations, responsibilities, and consequences.

During the annual compliance review, observations confirmed staff and youth interaction adhered to the BMS and staff addressed youth behaviors in a ratio of four to one positive reinforcement to negative consequences. A program tour found multiple postings of the BMS guidelines, various weekly awards given to youth, incentives available, and tracking available for youth. An interview with the FA indicated the program utilizes a token economy (point system) to reinforce positive behavior with the youth. The system ensures positive consequences outnumber the negative consequences. 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 to include daily incentive activities, canteen items based on their level and earned points, increasing levels for additional privileges, and weekly awards in conjunction with school staff. The program also utilizes “gotchas” which recognize youth who exemplify good behavior. If a youth receives twenty “gotchas” they receive a meal from McDonalds. Five staff were interviewed and was able to explain the program’s BMS and were knowledgeable of the rewards provided to youth. Each staff stated things cannot be taken away from youth as a consequence. Five youth were interviewed and each was able to describe the BMS, was aware of the punishment and consequences used in the program, and was able to describe the rewards used in the program.

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

The program has a policy and procedures to ensure staff are provided feedback regarding the implementation of the behavioral management system (BMS). A review of the BMS indicated the BMS is not used to increase a youth’s length of stay, deny basic rights or services, promote the use of group punishment, allow youth to punish other youth, or include disciplinary confinement. The program includes a process in which the Problem Behavior Report (PBR) is written for staff to explain to the youth the reason for any imposed sanctions. Youth are given an opportunity to explain their behavior in the youth comments section of the PBR and during any special treatment team meetings. Special treatment team meetings are held for youth whose behavior needs immediate intervention. The program does not utilize room restriction for major infractions. A random review of five staff job descriptions indicated BMS implementation is addressed as a part of the staff’s daily functions. In addition, five pre-service and five in-service personnel records were reviewed and found staff are evaluated after the first ninety days of employment and annually thereafter on their use of the BMS. The program has an annual in-service and pre-service training plan which includes the BMS for all staff and a review of five pre-service and five in-service training records verified training was completed as required. The

program has an agreement with the Osceola County School District related to the BMS and verified teachers are trained in the implementation of the BMS. An interview with the facility administrator (FA) indicated the points system is reviewed each shift by the shift manager along with the PBRs to see if any other action is needed. The number of youth who made their day is reviewed in the morning meeting. According to the FA, the BMS is monitored to ensure it is administered fairly and consistently among all staff by shift briefings and having each department staff attend special treatment team meetings to ensure the BMS guidelines are completed as intended. Five youth were interviewed and all stated staff are fair and consistent in the use of rewards and consequences. Five staff were interviewed and stated youth are informed of the consequences and are given an opportunity to explain their behavior. All interviewed staff also indicated supervisors provide feedback to staff regarding the implementation of the BMS by having one on one sessions and during the daily shift briefings.

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

The program has a written policy and procedures which ensure an effective means for room checks whenever a youth is in their sleeping room. Once the program has lights out and youth are sleeping in their dorms, the policy requires master control to initiate room checks at intervals not to exceed ten minutes. Program practice is for master control to notify staff on the living units to conduct checks every eight or nine minutes using the radio system. Master control maintains a log of when they radio all of the dorms to conduct their checks. The intervals documented between checks was reflected to mirror these being called out every nine minutes, at a minimum. Individual staff are positioned in each dorm, in accordance with the one staff to twelve youth ratio during sleeping hours. When the check is called, staff are required to walk down the hallway, stopping to look into each room to see the skin or a body part of each youth before moving on to the next room. Staff record these checks on the visual check sheet with the time of the check and their initials. A review of the visual check sheets confirmed checks were being completed when the staff were notified by master control. The program indicated their digital video record system (DVR) maintains thirty-days of information. Six different nights/evenings were randomly selected for review for the two youth modules. The program reported having 100 cameras on their campus and only one is not functioning properly. This is in the administration area next to master control in an area called “search hallway”. This camera is not working due to water damage caused during the installation of the cameras. The program has a contractor who is scheduled to come out and repair the issue soon. The video review for the six selected periods revealed no discrepancies in the conducted checks and the documentation found on the visual check sheets. The observations of staff also found staff pausing at each door to conduct visual verification for each youth during the cycle of room checks. Interviews with five staff found each knew the program conducted checks on youth at least every ten minutes while the youth were sleeping. Two staff indicated they are conducted every eight to ten minutes. An interview with the assistant facility administrator (AFA) responsible for ten-minute checks reflected, they conduct reviews of the visual room checks every day they work.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

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

The program has a policy and procedures regarding census, counts, and tracking of youth. The program maintains a running census count on a whiteboard in the shift briefing area. The census count indicates the current count population in-house and which youth are out of the program. This information is also maintained in the master control logbook. The policy requires master control to conduct at least three formal counts within each twenty-four hour period. No specified times for these counts are given. A review of logbook documentation confirmed counts documented as scheduled and unscheduled, are being conducted every hour of the day with minor variances seen. The program is required to ensure all youth are accounted for at all times through a system of physically counting youth at various times through the day. The review of the master control logbooks found formal headcounts being conducted at the beginning of each shift and counts being conducted after emergency situations. Specific formal headcounts were not seen after each outdoor activity; however, the program was specifically documenting the movement of youth to and from each area and documenting the number of youth in each movement. This assisted in staff being able to know where their youth are at any given time. Observations of formal headcounts were conducted during the annual compliance review, with no exceptions being seen. The staff were observed calling in each movement of youth for master control to acknowledge and record in the master control logbook. Only one exception was noted with this process, which was observed after a discrepancy with movement from a living module to a classroom was observed by the review team. In this instance, there was confusion regarding the location of all youth and an improper number of youth was recorded for the movement. The unscheduled headcount which was conducted following this error found all youth were accounted for. Informal interviews with staff during the annual compliance review found they were aware of how many youth were with them without having to stop and count the youth before responding. Five staff were interviewed regarding when youth counts are conducted. Three staff indicated counts are conducted hourly throughout the day, one indicated they are conducted four to five times during each shift, and one reported they are conducted every thirty minutes during the day. The staff indicated all movement would stop and they would immediately conduct a recount if the count is not correct. Three indicated all youth would be locked down and they would continue to conduct counts until they could clear the discrepancy.

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

The program has a written policy and procedures regarding logbooks and shift reports. The program has a master control logbook which is maintained by a master control worker. A review was conducted on the master control logbooks from the annual compliance review period. The logbooks contained a chronological record of events, incidents, and activities occurring in the program. Each logbook was bound with numbered pages and contained entries regarding admissions and releases, emergencies, security risks, incidents, transports, perimeter security checks, law enforcement visits to the program, youth placements into controlled observation, population counts at the beginning and end of shift, and staff assignments. Each logbook entry included the date and time of the event, names of staff and youth involved, and a very brief description of the event following the time of the entry. There were no entries found to be obliterated or removed and any errors were struck through with a single line and initialed by the staff correcting the error. The master control staff were not writing their name or signing after each recorded entry, as required. Program practice is for the master control staff to sign the logbook after their final entry of the day and to draw a line indicating the remainder of the page is void and signing again at the bottom of this area. Observations found shift supervisors and other staff making entries during shifts without signing their entries, making it difficult to identify who made the entry. Additionally, entries made by supervisory staff in red ink were seen to document perimeter checks. These entries were initialed at times but this was found to be inconsistent. All applicable incidents for calls placed to the Department's Central Communications Center and/or the Florida Abuse Hotline were documented in the logbook.

The program completes a shift report to share important information with oncoming staff regarding the previous shift. Prior to staff reporting to their assigned living unit, a shift briefing is held in the briefing/conference room to review any important information from the previous shift, and any information which staff need to be aware of. A review of the shift reports for the annual compliance review period found they contain youth census information from the beginning and end of the previous shift, status of absent staff, intakes/releases, staff assignments, youth alert information, and other important incidents which occurred during the previous shift. The shift report was then signed by all staff present in the shift briefing. A copy of each shift report is maintained in the sub-control area which is easily accessible between the two living modules, for at least forty-eight hours. A shift briefing was observed during the annual compliance review and verified this process.

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 for the control and accountability of all keys in the facility. The program has a system in place to govern the control and use of keys including key assignment and usage, inventory and tracking, secure storage, procedures for missing or lost keys, and reporting and replacement of damaged keys. All of the program's active keys are housed in locking cabinets in the master control area. There is also a smaller red locking box in the master control area which houses an emergency set of 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 which is only accessible by master control operators and program administration. The restricted keys are each labeled with the title of staff allowed to access them. A shift change was observed during the annual compliance review and direct care staff were observed turning in their keys to master control. They documented the time they turned in their keys, along with their signature and the initials of the master control staff who received the keys. The staff then reported to shift briefing where they are given their unit assignment. Following the briefing, staff reported to their assigned unit and program keys are passed from the previous shift to the current shift. The outgoing staff then documented they passed on their set of unit keys to the new staff with the time this was done. Master control staff also completed a "Daily Key Control Inventory Log" which reflects accountability for all facility keys. Interviews with a master control operator confirmed their knowledge of the procedures for addressing missing or lost keys, the reporting, and replacement of damaged keys. There were no reported incidents of lost keys or staff leaving the building with access keys to the program during the annual compliance review period. Observations of all facility keys confirmed all keys were maintained on a tamper-resistant key ring, designed to inhibit the removal of keys. Six key rings were randomly selected. Comparison of these rings to the master key inventory found each of the key rings matched what was reflected on the document. The program conducts a monthly key inventory of all keys and the master key inventory is updated when changes are made. During the annual compliance review, random checks of three staff found each was carrying only facility keys on their person at all times and youth did not have access to handle facility keys. Five staff were interviewed and each indicated a working knowledge of key security and process for reporting and replacing of damaged keys. Visitors keys are taken and placed in a special section within the sub control key cabinet on their own numbered hooks. Each visitor is provided a numbered tag which has the corresponding number for the hook on which their keys are placed.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program has a written policy and procedures to prevent the introduction of contraband into the facility. The program's policy defines certain items and materials to be considered contraband when found in the possession of a youth. This list includes illegal items, sharps, escape paraphernalia, drugs (to include prescription or over-the-counter medications), tobacco products, electronic or vaporless cigarettes, non-program issued/Department issued electronic equipment or devices, unauthorized food or beverage, metals, cell phones, cash, flashlights, pornography, aerosol cans, ropes or wire, keys, and any items deemed unsafe or a threat to facility security or not specified as approved in the youth handbook. 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. Each youth is oriented on all items considered to be contraband on the day of admission, along with the penalties for having any contraband items in their possession. There was documentation to support the program conducted and documented searches of the common areas, on a daily basis at least once each shift. This common area search documentation is maintained in its own binder. Perimeter searches are conducted by a supervisor at least once each shift. This information was documented in the master control logbook. The program was able to provide additional binders which reflected contraband searches being conducted on each youth room once a week. This frequency was in line with the procedures found in their policy. All items deemed contraband were documented for the corresponding youth room and most items were disposed of. No illegal contraband was found for any of the reviewed room search forms. The program had an incident in May of 2019 in which cellular phones were found in the possession of youth. It was determined these were brought into the facility by family members during a family day held by the program. An interview with the facility administrator (FA) confirmed these items were maintained in their possession and are available to law enforcement if ever needed for an investigation. The FA was able to provide a review team member phones which had been confiscated at the program. A review of visitation documentation for the annual compliance review period reflected all visitors are searched prior to entering the program for visitation. The policy requires each youth to have a full body visual search following each visitation. Youth search forms were found attached to the weekly visitation documentation for each youth during the past six months. Interviews with an assistant facility administrator (AFA) reflected staff will notify one of the AFAs or the facility

administrator (FA) if any illegal contraband is found and it will be turned over to law enforcement. Any illegal contraband which does not impose a safety and security risk to the program, such as cell phones which are not confiscated by law enforcement at the time of discovery, is kept by the FA in a secured location and is available for law enforcement if needed. The program will also notify the Department's Central Communications Center (CCC) within two hours of discovery and will initiate an internal investigation.

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 regarding searches of youth. The policy requires youth to be searched by male staff prior to movement from one area to another. The program also conducts full body visual searches on youth at the time of their admission to the program, when visitation is completed, when there is a reasonable suspicion a youth is concealing contraband, and when youth return from being off-campus, if applicable. These searches are required to be conducted by two male staff. Observations during the annual compliance review also confirmed youth were searched before movement from one program area to another. Each observation found staff conducted searches according to program policy and with respect to the youth. During one observation in a classroom, a youth was found to have a pen in their waistband. The searches were documented in the logbook as having been conducted for each movement. Reviewed documentation confirmed the completion of full body visual searches when required. A full body visual search was completed on a new admission during the annual compliance review. An interview with a staff member responsible for transports confirmed their practice whenever youth are taken off-site. The staff was also able to provide the forms they review and complete with each youth prior to the search. The staff indicated this is always conducted with two male staff, or a male staff and a nursing staff. Reviewed documentation confirmed this practice. All five interviewed staff reported youth are searched prior to each movement. Each staff indicated these searches were only conducted by male staff. Five youth were interviewed and each reported they are searched anytime they move from place to place.

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

The program has a written policy and procedures in place to address vehicles and maintenance. The program has two fifteen passenger vans which are used to transport youth. Random inspections during the annual compliance review found the vans locked. Both of the vans are equipped with a security screen and each was found to have functioning seatbelts for youth and staff. Each of the vans were equipped with a fire extinguisher which was inspected by a fire safety company in January 2020. Both vans were inspected by a review team member. The key ring for each van was found to include a tool which was an emergency seatbelt cutter and a window punch. Additionally, each van has a larger rescue tool available for use which is stored

in each of the vans. The program also has a first aid kit for each of the vans which are stored in master control and are checked out for each transport. The items inside the kits are not subjected to the elements and can be easily replenished. Annual vehicle inspections were provided for both vans used to transport youth. Vehicle maintenance information was shared for the applicable van with all concerns having been addressed. A transport was able to be observed during the annual compliance review for a youth who was leaving for a medical appointment. This observation found two staff going to a classroom to get the youth who was to be transported. The youth was taken to the main hallway, searched, and placed in handcuffs and shackles for transport. The two staff escorted the youth out the front of the facility and assisted the youth into the seat while assisting in placing the seatbelt on the youth. The two staff applied their own seatbelts prior to leaving for the transport. An informal interview with the staff responsible for transports indicated both staff and youth wear their seatbelts during all transports. Interviews with the staff responsible for transports and a master control operator indicated they have a cellular phone which is available for transporting staff. Formal interviews with five staff also reflected staff being provided with a cell phone for use to communicate with the program during youth transports. Two of the staff indicated staff will also have a radio assigned as well.

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

The program has a written policy and procedures for the transportation of youth. A transport was observed during the annual compliance review when a youth was transported to a medical appointment. The program's designated transport staff was the driver and had a cellular phone provided by the program for use. There were two staff present for the one youth. The policy indicates a ratio of at least one to five while transporting youth, while always having at least two staff present with at least one staff being the same gender as the youth. An interview with the staff responsible for transports confirmed the program will always have two staff present during transports. The program maintains an approved driver list which is maintained by the program's human resources specialist. The program's human resources specialist check each transporter's driver's license monthly and certifies the approved driver's list. Observations of the youth transport confirmed the use of seatbelts for both staff and youth. Interviews with the staff responsible for transports and a master control operator indicated they have a cellular phone which is available for transporting staff. Observations during the annual compliance review found program vehicles were locked when not in use. Perimeter checks include a check of the security of all vehicles, program and personal in the parking lot. One personal vehicle was found unlocked during the annual compliance review. Once discovered the review team member notified the master control worker who was able to find the owner to have them secure their vehicle. Interviews with five staff indicated staff are not allowed to use their personal vehicles to transport youth.

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

The program has a policy and procedures in place to address weekly safety and security audits. The reviewed documentation found one of the program's assistant facility administrator's (AFAs) completes the Facility Security Audit and Safety Inspection weekly. This document includes checks of program areas including surveillance, communication equipment, doors, metal

detectors, mechanical restraints, sally port, transportation vehicles, youth rooms, classrooms, kitchen/dining area, grounds inspection, exterior structures, perimeter, chemical storage, and tool and sensitive item control. Weekly safety inspections are maintained in a binder which contained Facility Security Audit and Safety Inspections during the annual compliance review period. Documentation included comments on concerns and information relating to corrective action which was needed for any identified problems. An interview with the AFA revealed all physical plant concerns are tracked by the management team and are addressed in their meetings. All safety and/or security issues pending repairs are tracked by the management team. This process was confirmed through an interview with the facility administrator (FA). The FA indicated corporate staff would also track any security deficiencies to ensure these concerns were being addressed.

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

The program has a written policy and procedures which address tool inventory and management. The program's tool management procedures include tool identification, inventory procedures, training, and oversight. The program maintains Class A and B tools on-site. Observations and inspection found a locked laundry room on each of the living modules where Class B tools such as mops and brooms are stored. All Class A tools were maintained in the maintenance shed which is not accessible to youth. All tools were marked with a numbered sticker which clearly matched the numbers on the tool inventory. The program uses a shadow board system where all tools have a red space in the shape of the tool to easily identify if a tool is out of place. Random checks of tools were conducted and all were found on the program inventory. A daily check of all tools is completed by one of the maintenance staff each day staff work. When a tool is used, it is checked out on the log in the tool area and checked back in at the end of the day or when the project is completed. The program maintains a binder containing all monthly inventory sheets which documents the verification of each is present in the storage area. The program also maintains a log for each dormitory which staff utilize to track the signing-out and signing-in of each Class B tool as it is used each day during clean-up activities. All kitchen tools and knives are maintained in a locked box inside a locked filing cabinet in the locked food service manager's office. This box is only accessible by kitchen staff. A daily check of all kitchen utensils and knives is completed by the food service staff each day. When an item is used, it is checked out on the log and signed back in once the item is no longer being used. A review of five case management records confirmed each youth was trained on the safe use of Class B tools. Observations of a shift briefing found the shift supervisors reinforcing the message about not letting new admissions use class B tools until the youth have passed a risk assessment. The review of five pre-service staff training records also reflected each staff being trained on the safe use of tools. Five staff were interviewed and each confirmed youth are only able to utilize a scrub brush, mop, or broom and always under the supervision of staff.

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

The program has a written policy and procedures regarding youth tool handling and supervision. A review of five staff training records documented receipt of tool safety training during pre-service training. Five youth case management records were reviewed and confirmed youth were

trained on the usage of Class B tools. Prior to a youth is permitted access to a Class B tool, a risk assessment is completed to determine the youth level of risk to harm themselves or others. Observations of a shift briefing during the annual compliance review found the shift supervisors reinforcing the message about not letting new admissions use class B tools until they have passed a risk assessment. The program does not have any specific vocational programs which require the use of Class A tools by youth. The youth assist with basic cleaning, which was not able to be observed during the annual compliance review. Interviews with five youth confirmed they only use mops brooms, and scrub brushes. All of the interviewed youth reported being able to use a mop or broom. The five interviewed staff also confirmed youth will only use a scrub brush, mop, or broom while under supervision.

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 maintains a written policy and procedures for how they will manage and supervise outside contractors. The policy requires a physical plant staff to maintain constant supervision of all outside contractors while they are on-site. Youth are not allowed access to the area where outside contractors are working. The policy indicates outside contractors will be provided with instructions to follow while in the facility and all tools or needed instruments will be inventoried prior to entry. This is completed on a specific form which tracks the tools brought into the facility and used to validate the same tools are present and removed from the facility by the contractor when they leave for the day. Any areas the outside contractor worked in are searched after the work is complete. Interviews with the human resources/business manager who helps translate for the physical plant manager, revealed outside contractors are given verbal instructions on the procedures to be followed and penalties for bringing contraband into the facility are explained prior to their entry. The program requires all outside contractors to sign-in on the visitor log. This log reflects the contractor to turn in their keys and being searched prior to entry. The master control logbook reflected the dates, times, and nature of service calls. A review of the program's repair invoices confirmed outside vendors signed the visitor's log on the dates in which services were provided. A review was conducted on the outside contractor binder to ensure there was a corresponding form which reflected the completion of a tool inventory list which documents what items and/or tools were brought on-site. The vendor and supervising staff each initialed when the tools came in and left. This documentation was found for all five randomly selected contractor visits. The program will put together a written list of expectations, to include the specific list of items considered contraband for outside contractors to acknowledge as part of their process when checking in to complete a work task.

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

The program has a policy and procedures in place addressing fire, safety, and evacuation drills. The policy requires drills to be conducted every month and on every shift. An interview with one of the assistant facility administrators confirmed fire drills are conducted monthly on each shift, and other emergency drills are conducted at least once a quarter. The drill binder for the program was also found to include a drill schedule which includes the topics for the drills which will be completed each month. A review of the program's drill documentation found the program completed fire drills monthly on each shift during the annual compliance review period. Four of

the twelve reviewed fire drill forms did not have documentation reflecting whether there were or were not any deficiencies or any corrective action needed which may have been based on the actions of youth and staff during the drill. This was observed to be sporadic throughout the reviewed drills. The review of drill documentation also found the program completed an emergency drill in four of the past six months. These drills addressed weather situations including a hurricane drill, escape, gang concerns, program disturbances, and a bomb threat. Five youth were interviewed, and each stated they have been instructed on what to do in case of a fire. Four of the youth reported fire drills occurs at least once a month and one indicated they are conducted twice a month. Five staff were interviewed regarding the types of drills they have participated in during the past twelve months. Five indicated they participated in medical drills, four indicated they participated in weather and escape drills, three indicated they participated in a major disturbance drill, and two indicated they participated in a suicide drill. Observations during the annual compliance review confirmed the program has egress plans posted for staff and youth to reference in any emergency situations where emergency evacuation is needed. Further observations confirmed all fire extinguishers were inspected in January 2020.

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

The program has a written policy and procedures which details all aspects of the Continuity of Operations Plan (COOP). The program's COOP was reviewed and approved by the Department on March 25, 2019. An interview with the facility administrator as well as observations made during the annual compliance review, confirmed the program maintains a copy of the COOP in master control, the facility administrator's office, and the offices for each of the assistant facility administrators. The COOP addresses alternative housing plans, vendor contact list, emergency staff contact numbers, and county cooperation checklist. In addition, the COOP included a plan for maintaining youth records in the event of an emergency which included all required elements. The program provided documentation reflecting COOP drills were conducted four of the previous six months which included scenarios such as weather, safety, escape, and a bomb threat. The drills were documented in the logbooks and on facility drill forms. A review of the program's COOP drills indicated the drill forms includes a synopsis of the drill, the date, the time, what type of drill was being conducted, any deficiencies identified, any corrective action needed, and the staff involved.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	**Limited 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 to address the storage and inventory of poisonous, flammable, and toxic items. An inspection of the area where the chemicals are

stored found all chemicals were in a locked cabinet in the kitchen, in a storage closet in the main hallway, and in the maintenance shed with flammables being stored in a locked cabinet next to the maintenance shed. There were Safety Data Sheets (SDS) and current inventories for all of the chemicals stored in the maintenance area and in the kitchen. Concerns were noted upon inspection of the storage closet in the main hallway. The program stores a working stock of chemicals maintained in this closet for use on the living units. The items on the "Chemical Sign IN/OUT Forms" for each living unit are Pine-Sol, Fabuloso, Windex, Clorox, and Perfect Stainless. There is not an inventory of what is present in this closet only the sign-in and sign-out log. There are multiple bottles of bleach which are checked out by the different living modules for use in their laundry. The lack of an official inventory does not allow for an official accounting of where or how many of these items exist at any given time within the program. There were also two items in the closet which were not on the sign-out or sign-in forms. Each living module has a bucket in which they take cleaning chemicals to the unit. There are spray bottles for the chemicals. Although the chemicals seem to have a specific color, none of the bottles are specifically labeled so the user would know what is in any given bottle. There is an SDS binder in this closet which has information about the five chemicals on the sign out and sign-in log; however, there is no information for two specific cleaning chemicals which were found in the closet. The program made adjustments to this area during the review. The program removed all of the loose chemicals out of the closet and implemented a new system. Each of the living units will have its own bucket which will hold five bottles containing the five approved cleaning chemicals. Each of these bottles will be clearly labeled with the contents. These bottles will be filled each morning by maintenance staff to ensure there are adequate supplies for each unit to use during the day. Each unit will sign out their bucket and will sign it back in when they are done conducting cleaning activities. No chemicals are stored on the youth dorms.

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

The program has a written policy and procedures which prohibits youth from having access and using any flammable, poisonous, and/or toxic materials. The program maintains strict control of these items. Youth are restricted from the areas where flammable, poisonous, and toxic materials items are stored. Observations made during the annual compliance review confirmed the youth in the program do not have access to the areas where the toxic items are stored or used. The ongoing perpetual inventory for these cleaning items matched the quantity of each remaining item with the exception of those maintained in the storage closet in the main hallway. During the annual compliance review, the program implemented a new system to maintain control of what is stored in the storage closet. Interviews with five youth revealed four assisted

with repainting the living units and one indicated they assisted with applying wax to the floors. All five youth indicated they are never allowed to handle any chemicals. They indicated these are always handled by staff and they just assist or with cleaning.

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

The program has written policy and procedures for the disposal of flammable, toxic, caustic, and poisonous materials. These types of hazardous materials are to be disposed according to Occupational Safety and Health Administration (OSHA) requirements. An interview with the facility administrator revealed the program only purchases what they will use and not had to dispose of any chemicals during the annual compliance review period. The physical plant manager also indicated during an interview, the program did not have to dispose of any chemicals during this annual review period.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has policy and procedures to address visitation, telephone access, and correspondence. An approved visitation and telephone call list are developed upon a youth's admission throughout their orientation process. Feedback and input for this list are obtained from the youth's juvenile probation officer and parent/guardian. A copy of this list is maintained in each's youth's case management record and in the visitation binder, which is stored in master control. Visitation is held every Saturday from 1:00 p.m. to 4:00 p.m. Information regarding visitation is mailed to each youth's parent/guardian upon the youth's admission to the program. Visitation is usually held in the multipurpose room in the other program co-located on the same site. A review of documentation confirmed visitation was conducted each week. A review of telephone logs confirmed youth were receiving telephone calls on a weekly basis which were facilitated by the case management staff. This was verified through documentation seen on each youth's call logs. The program documents received mail on a form in their case

management record. An interview with a case manager revealed they log, open, and inspect all mail with the youth present. This process mirrors what is described in the program's policy. All five interviewed youth indicated they have been given the opportunity to communicate with family members by mail, telephone, or at visitation.

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

The program has policy and procedures for the use of controlled observation. The policy requires the observation room to be searched prior to placing a youth in the room and the youth to be searched by a staff member in the presence of another staff prior to leaving the youth alone in the room. The program utilizes the two rooms at the end of each living module for controlled observations. If the program population is at capacity and these rooms were not vacant, the program has two rooms in the medical clinic designated for this purpose. All of the rooms which may be used for this purpose meet the size and construction requirements as specified in the Florida Administrative Code. The walls had no vents, electrical outlets, or any anchor point which could pose a potential risk to the youth. The observed rooms were clean and without of any kind of decorations or other items. There is a shatterproof window on the door of each room to ensure staff are able to observe the youth at all times. The program utilized controlled observation forty times during the annual compliance review period. Five reports were randomly selected to be reviewed. Each report documented a search of the controlled observation room was conducted prior to placing the youth in the room. None of the room searches yielded any contraband. All five controlled observation reports documented a male staff conducted a search of the youth prior to the youth's placement in the controlled observation room. There were no instances when contraband was found on a youth during the search prior to placement in the controlled observation room.

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

The program has policy and procedures for the use of controlled observation as an emergent safety situation for youth identified for such placement due to imminent risk of harm to self or others, active involvement in property destruction which would compromise the safety and security of the facility, and as a last resort youth at imminent risk to escape. The program utilized controlled observation forty times in the six months prior to the annual compliance review. Five reports were randomly selected to be reviewed. Each report documented the procedures completed before and during the placement as well as the duration of the placement. None of the five reports documented the youth exhibited behaviors indicative of acute psychological distress to include a mental health crisis or suicide. All five reports documented authorization of the placement by the facility administrator (FA) or designee. The reports documented the placement of the youth in controlled observation due to active aggression towards others. All five reports documented the youth was advised of the reason they were placed into controlled observation as well as the behavior expectations for the youth to be reintegrated back to their unit. All five reports included a Health Status Checklist which was completed by a male staff member at the time of placement. Four of the reports reflected a placement of more than two hours requiring FA or designee approval. There was documentation the placement was extended after receiving approval for each two-hour period beyond the initial

two hours they were in controlled observation. None of the placements exceeded twenty-four hours, with the longest being nine hours.

5.25 Controlled Observation Safety Checks Release Procedures	Satisfactory Compliance
The program shall conduct safety checks for youth on Controlled Observation. The program director or designee shall approve a release when it is determined, based on his or her behavior, the youth is no longer an imminent threat to self or others.	

The program has a policy and procedures regarding safety checks for controlled observation and to address the youth's release from controlled observation. The program utilized controlled observation forty times during the annual compliance review period. Five reports were randomly selected to be reviewed. None of the youth required continuous sight and sound supervision due to risk for self-injury. All five reports documented checks were completed every fifteen minutes for the duration the youth was in controlled observation. It was observed staff documented the time of the check, the observations of the youth according to numbered menu, and then initialed their entry. All controlled observation safety checks were documented on the form as required by the Department. Each controlled observation report indicated the youth was released from controlled observation by authorized staff after an interview with the youth. Each report documented the youth's release from controlled observation was based on the successful de-escalation of the youth and the youth was no longer displaying behavior which led to the placement. Each release was approved by the facility administrator or designee. Each report documented an administrative review addressing the appropriateness of the placement and any need for a change in the youth's in-house alert status within the program. A review of three youth records found a copy of the controlled observation report, the Health Status Checklist, and the controlled observation safety check forms are maintained in an administrative file not in the youth's record.

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

The program has a policy and procedures on safety plans and has established safety plans for all youth as required by the July 1, 2019 mandate. Although the program has a policy which was written, it had not formally been approved at the time of the annual compliance review. The safety plans include warning signs, youth's baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies preferred by the youth, and debriefing preferences. Five youth records were reviewed and all youth were admitted after the mandate for safety plans. Each had their initial safety plan completed on the day of their admission to the program. The review of records found the program may not have understood the requirement for updates to the safety plan every thirty days since the program did not start doing these updates for all youth until October 2019. Each of the youth had a safety plan update in October. The program adjusted their form to add a space to reflect a review of collateral information and discussion with the parent/guardian for the assigned therapist. The program utilizes a group session of Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) to complete the updates for each youth. Two of the reviewed youth had no safety plan update in November and the remaining three youth had their update completed five days late. Each of the reviewed youth had a safety plan update in December which was completed fourteen days outside of the thirty-day requirement. The program updated each youth's safety plan in January within the thirty-day

time frame. There was no documentation present to reflect any other treatment team members other than the therapist, took part in the completion of the safety planning process; however, all of the treatment team members were found to have reviewed and signed the plans and updates. Five youth were interviewed regarding the safety planning process. Three of the youth indicated they were involved in the process, one indicated they were not involved, and the remaining youth did not know what a safety plan was. Formal interviews were also completed with five staff. Two of the staff indicated the plans are stored in the briefing area, two stated they were in the sub-control area by the living units, and one stated they were on the modules posted on the board. Observations and interviews during the annual compliance review confirmed the binder with current safety plans is maintained in the briefing room in the administration area of the building. Three of the interviewed staff were unaware of the process the program uses to review or update the plans. One staff did know the safety plans are updated by the therapists. One staff indicated they are updated after certain treatment teams and another indicated they would notify the case manager or therapist about any behaviors relevant to the safety plan.