STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Kissimmee Youth Academy

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

Review Date(s): May 12 - 15, 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:

Tamara Mahl-Adkins, Office of Program Accountability, Lead Reviewer (Standard 4)
Teresa Andersen, Office of Program Accountability, Deputy Regional Supervisor (Standard 5)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 3)
Gustavo Mazorra, Office of Program Accountability, Regional Monitor (Standard 2)
Gregory MahoumNassar, Office of Program Accountability, Regional Monitor (Interviews)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard 1)

Program Name: Kissimmee Youth Academy
Provider Name: Youth Opportunity Investments, LLC
Location: Osceola County / Circuit 9
Review Date(s): May 12 to May 15, 2020

MQI Program Code: 1468
Contract Number: 10287
Number of Beds: 24
Lead Reviewer Code: 156

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
1.20 Recreation and Leisure Activities	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

* 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 *	Satisfactory

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth 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 (KYA) is a twenty-four bed program, for fourteen to twenty-one 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 the following services: Mental Health Overlay Services (MHOS). In addition, the program fosters each youth by providing Skill Streaming the Adolescent, Young Men's Work (YMW), Impact of Crime (IOC), Seven Challenges, Trauma Focused Cognitive Behavioral Therapy, Forward Thinking, and The Council for Boys and Young Men. Additional treatment services provided includes family and individual therapy. Program administration is comprised of a facility administrator, three assistant facility administrators, director of case management, designated mental health clinical authority (DMHCA), and clinical 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 DMHCA, who is a licensed mental health counselor (LMHC), one additional full-time LMHC, and a regional clinical director who is also a LMHC, four master's-level non-licensed therapists, and a contracted psychiatrist, psychologist, and certified behavioral analyst. Medical services are offered daily and are provided by a contracted designated health authority who is a licensed medical doctor and three registered nurses (RNs), with one of the RNs acting as the health services administrator (HSA).. All positions are shared with the KYA Borderline Developmentally Disabled (BDD) program. 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. The hallway houses the clinic, staff offices, the staff break room, and the administrative area. The program is located in one wing of the building and youth are housed in modules. The other wing is occupied by youth in the program co-located in the same structure under the same Department contract. The program has 108 security cameras providing coverage, each of which were operational at the time of the annual compliance review. At the time of the annual compliance review, the program had eleven vacant positions; which included two therapists, one cook, five youth care workers II, two youth care workers I, and one shift supervisor. All staff positions are shared and considered KYA staff and are not broken down by unit (BDD/MHOS).

Strengths and Innovative Approaches

- The program has revamped their student council program which require youth to apply and be chosen depending on the youth's level and behaviour to represent their peers. The student council has cultivated many creative and innovative ideas such as Distinguished Gentleman, pot lucks, and providing 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 have any visitors.
- The program scheduling the Florida Licensing on Wheels mobile on-site to issue Florida identification cards for the youth while they are in transition.
- The program has a chicken coop, a goat habitat, and a koi pond for an aquaponics garden. The goats are utilized to assist in lawn maintenance.

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 provision of background screenings for all newly hired employees. The program had nine new employees eligible for a background screening since the last annual compliance review. Each employee was found to have a completed eligible background screening in the Agency for Healthcare Administration (AHCA) Clearinghouse system which was completed prior to each staff's hire date. A review of all nine staff personnel records found the program reviewed each of the 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. All nine staff were eligible for and had documentation in their records indicating each 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. A review of the program's volunteer roster and sign-in logs verified the program did not have any volunteers or mentors which required background screening. The program did not employ interns during the annual compliance review period. The program utilizes teachers from the Osceola Public School System. Both the Affidavit of Compliance with Level 2 Screening Standards and the annual screening for the teachers were submitted to the Department on January 9, 2020.

1.02 Five-Year Rescreening	Non-Applicable
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 regarding the provision of a background rescreening every five years of employment for all staff. A review of the employee, volunteer, mentor, and intern roster found the program did not have any applicable staff for a five-year background rescreening during the annual compliance review period; therefore, this indicator is rated as non-applicable.

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 which outline the provision of an abuse-free environment for youth and staff. The policy outlines the requirements of staff to offer youth unhindered and immediate access to the Florida Abuse Hotline by facilitating the youth's request to make a call as soon as possible with no screening. The steps to report abuse are captured in the policy and include if a youth refuses to place an abuse call, staff must place the call if the staff has reasonable suspicion abuse has occurred. Staff shall notify the facility administrator (FA) and on duty supervisor as soon as the call to the Florida Abuse Hotline or the Central Communications Center (CCC), if applicable has been placed and the reason for the call. An internal incident report shall be completed and forwarded to the respective supervisor once the call has been made to the Florida Abuse Hotline or the CCC. The FA or administrative duty officer shall complete the appropriate notification to the CCC and the provider's Florida director. All notifications and follow-up information shall be included on the internal incident report document.

Observations made during the program tour found postings throughout the facility for the Florida Abuse Hotline and contact information for the CCC, for youth over the age of eighteen.

A review of five in-service staff records found each had a signed code of conduct in each of the personnel records and an acknowledgement of the employee handbook which further outlines the code of conduct for all staff.

A review of documentation indicated the program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment and used the results of the assessment to incorporate trauma-responsive principles into the program planning process. However, the TRACE document did not include the date and name of program; however, it was clear after reading the content, the information was concerning the program specifically. An email sent in February

2020, documented correspondence between the program and their corporate office regarding its completion, was reviewed.

Since the last annual compliance review the program had one substantiated incident related to physical abuse. This incident was called into the CCC and the Florida Abuse Hotline according to policy.

An interview with five youth found each stated feeling safe in the program and have never been denied from reporting abuse to the Florida Abuse Hotline. The youth reported staff treat youth with respect and have never heard staff use profanity when speaking with youth.

Each of the five interviewed staff were able to explain the process for youth and staff to call the Florida Abuse Hotline/CCC. The staff report the process includes notifying the supervisor, assistant facility administrator (AFA), and facility administrator (FA), and allow the youth and staff to make the call. Each of the staff indicated they have never observed staff deny a youth to call the Florida Abuse Hotline. All five staff indicated never having observed staff use profanity towards youth. The five interviewed staff reported staff and youth are made aware of contacting the Florida Abuse Hotline through handbooks, training, postings, and orientation.

The FA indicated during an interview, the code of conduct addresses work-place violence, theft, improper conduct, attendance, insubordination, and unethical or abusive behavior.

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

Since the last annual compliance review, the program had one allegation of abuse, which was substantiated and warranted management response. Documentation was reviewed indicating the internal investigation was completed and the allegation was substantiated for physical abuse. The staff involved resigned before being terminated from the program. The documentation supported management took immediate action to address the incident.

The facility administrator (FA) interview indicated the program had one staff with disciplinary action due to excessive/unnecessary force.

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 has a policy and procedures outlining a formal, internal, and confidential system for reporting incidents of possible abuse. The program had five incidents which were reported to the Central Communications Center (CCC) during the annual compliance review period, a decrease from the previous six months which the program had seven reports. Each of the five CCC incident reports were reported within the two-hour required time frame and documented in the program logbook. A review of internal incident reports and grievances found no additional incidents should have been reported to the CCC. The facility administrator (FA) reported staff have access to calling the CCC. When a reportable incident occurs, staff are to inform the shift manager and the information is conveyed to administration for the report to be made.

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

The program has a policy and procedures on the use of Protective Action Response (PAR) techniques for staff to utilize in maintaining control of youth. The program's PAR plan was submitted to and approved by the Department on January 28, 2020. The program had five PAR incidents during the annual compliance review period which is a decrease since the last annual compliance review. The program's PAR rate during the annual compliance review period was 1.38, which is below the statewide Residential PAR rate of 2.28. Each of the five reviewed PAR reports were found to have been completed by the end of the staff members workday and included statements by all staff involved. All five reports had a post-PAR interview conducted within thirty minutes of the incident with the youth. The reports were reviewed by a supervisor, PAR trainer, and the executive director or designee within the required time frame. One of the five PAR incidents resulted in an injury to the youth, the Central Communications Center (CCC) was contacted within the required time frame and a PAR medical review was completed. All reports were placed in a centralized file within forty-eight hours of the administrator signing each report. The facility administrator (FA) interview indicated staff follow the use of PAR, a mediation is completed between the youth and staff, and all documents related to the PAR are reviewed by the assistant FA.

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 policy and procedures outlining training for all new employees before contact with youth. On January 19, 2020, the program submitted a written pre-service training plan to the Department's Office of Staff Development and Training, which included all requirements.

A review of documentation indicated the instructors for the cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED) trainings were certified to deliver the curriculum. A review of the five staff pre-service training records indicated each staff completed over 120-hours of training which all were documented in the Department's Learning Management System (SkillPro). All five staff completed essential skills training in CPR, first aid, AED, Protective Action Response (PAR), professional and ethics, suicide prevention and intervention, emergency procedures, Prison Rape Elimination Act (PREA), active shooter, and child abuse reporting prior to contact with youth and within 180-days of hire. Of the five staff hired, two were hired in January 2020, two were hired in February 2020 and one in April 2020; therefore, their 180-days had not expired at the time of the annual compliance review. Each of the new hires had time to complete any remaining training.

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 a policy and procedures outlining annual training for direct care staff and supervisors. On January 19, 2020, the program submitted a written in-service training plan to the Department's Office of Staff Development and Training, which included all requirements. In addition, the program has an annual in-serve training calendar, which can be updated if needed. Each of the reviewed five in-service staff training records had documentation of cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), ethics, suicide prevention and child abuse reporting, and PAR update. Three of the five staff took the non-required active shooter training. Two of the five reviewed staff were supervisors and each completed the required eight hours of supervisory training. The five staff completed all other required trainings, including what is outlined in the contract. All training was documented in the Department's Learning Management System (SkillPro). Each of the on-site nursing staff held current certifications in CPR, first aid, and AED.

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

The program has a policy and procedures outlining the grievance process. The grievance process includes informal, formal, and an appeal phase. The first two phases should be completed within three days and the last phase completed within five days. The complaints are discussed and resolved regardless of the circumstances and are documented in a log. The youth place the grievance in a box, the supervisor checks the grievance box daily, and reviews the grievance with each youth. If the youth wants to proceed to the appeal phase, the program director reviews the grievance with the youth.

In each of the five staff pre-service and five in-service training records reviewed, the staff received grievance process training. The program maintains a binder with the last twelve months of grievances submitted. Since the last annual compliance review, the program had three grievances. Each grievance was resolved at the formal phase within the required time frame of three days. Five youth and staff were interviewed and each were able to explain the grievance process in detail. Each youth reported being able to request assistance when completing the grievance form. The facility administrator (FA) reported, youth have access to grievance forms within each dorm. Once the form is completed, the youth places the grievance in the grievance box, which is then checked daily and reviewed by administration.

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 has a policy and procedures outlining staff providing delinquency interventions and the implementation of interventions for youth in the program. The program has staff trained in either life skills training, Seven Challenges or Impact of Crime (IOC) to facilitate these interventions. Each staff hold a master's-level degree and have at least two years of experience working with youth. The weekly program schedule includes allotted times for each of the groups. The sign-in logs and progress notes confirmed groups are being conducted as scheduled. The program's activity schedule provides structured, planned programming, or activities during at least sixty percent of each youth's awake hours. Youth are assigned groups based on their individual need's assessments. A review of five youth records indicated all youth participated in IOC and two youth participated in the Seven Challenges groups during the annual compliance review period. Each youth had an individual performance plan (IPP) addressing substance abuse or other needs with appropriate interventions. Each of the five interviewed youth reported participate in groups while in the program and all indicated they attended IOC since being admitted to the program. The facility administrator (FA) reports staff is determined the best match for each youth's needs during the classification meeting.

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 outlining life and social skills intervention services. The services address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management and critical thinking, including problem-solving and decision making. The program facilitates Life Skills training and Skill Streaming the Adolescent, which addresses substance abuse prevention and teaches social and self-management skills. The program has a weekly schedule which includes allotted times for life and social skills training. A review of sign-in logs and the Department's Juvenile Justice Information System (JJIS) confirmed each youth are receiving life and social skills training, as scheduled. One of the five interviewed youth reported attending the Skill Streaming group, the remaining four youth did not report attending this group. However, each youth reported learning new skills such as anger management, how their actions impact their victims, and coping skills.

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

The program has a policy and procedures for restorative justice services for youth in the program. Restorative justice interventions provide activities to assist youth in accepting responsibility for harm caused by their criminal actions, challenging to recognize and modify irresponsible thinking. The program conducts Impact of Crime (IOC) and has various activities

to address restorative justice. Youth complete community service hours through agriculture projects including feeding the animals and taking care of the chicken coop (chickens, geese, and goats), and the koi pond which are on-site in a secure location. The program maintains sign-in logs documenting each youth participation in restorative justice activities or groups. The program's weekly schedule includes allotted times for restorative justice activities. All staff conducting the groups completed the required training. A review of five youth records revealed each youth received and participated in restorative justice groups and activities. The facility administrator (FA) reported IOC is held weekly and youth are required to complete community service projects, as part of restorative justice activities. The FA also reported youth clean graffiti from the property and observes their finished work to show the youth the importance of keeping their neighborhood and surrounding neighborhoods clean.

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 has a policy and procedures regarding youth receiving gender-specific intervention. The program Male Healthy Relationship curriculums targeting the male population. The interventions are conducted weekly by the therapist. All youth participate in the groups as evident by sign-in logs and progress notes. The weekly schedule included times for gender-specific programming to be held. The facility administrator (FA) reported the program conducts Distinguish Gentlemen monthly dinners, and Male Healthy Relationships to address gender-specific intervention.

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

The program has a policy and procedures for the program to maintain an internal alert system on a consistent basis which will notify staff of any risk youth may have. Three of the five reviewed youth records were applicable for alerts. The remaining two youth did not have any alerts. Verification of alerts was conducted and found documented in the Department's Juvenile Justice Information System (JJIS) and the internal alert system. Each of the applicable alerts were documented in the program's logbook and each applicable youth were removed or downgraded when necessary by appropriate staff within the required time frame. Each of the five interviewed staff reported they are made aware of alerts through the alert board in the conference room and staff meetings. The facility administrator (FA) reported all areas including medical staff meet daily to discuss alerts. The director of case management, clinical director, and medical staff are responsible for entering and closing alerts in JJIS.

1.15 Youth Records (Healthcare and Management)	Satisfactory Compliance

The program maintains an official case record, labeled "Confidential," for each youth, which consists of two separate files:

- *An individual healthcare record*
- *An individual management record.*

The program has a policy and procedures regarding the maintenance of confidential youth records to include health, mental health, substance abuse, and other related treatment for each youth in the program. The program separates each youth record into three individual records including a healthcare record, mental health/substance abuse record, and case management record. Each of the five youth records contained the youth's name, the Department of Juvenile Justice Identification number (DJJID), date of birth, county of residence, and committing offense. Each of the five youth records contained the following sections: legal information, demographic/chronological information, correspondence, case management/treatment team activities, and miscellaneous. Each youth record was labeled "confidential" and stored in a locked and secured room which is accessible to only the case managers, facility administrator (FA), and therapist.

1.16 Youth Input	Satisfactory Compliance

The program has a formal process to promote constructive input by youth.

The program has a policy and procedures addressing the opportunity for each youth to provide their input regarding the rules and operation of the program.

The program has a student council, youth surveys, and request forms as process for youth to provide input on program activities. The youth can make suggestions on ideas to make the program and their time at the program better, as well as, any areas of improvement each youth would like to improve on, and suggestions for different places for community service hours to be completed. The results of the student council meetings, request forms, and surveys are reviewed by administration for implementation. The student council meetings are held twice a month to review new and previous meeting ideas. Each of the five interviewed youth reported youth are given the opportunity to provide input about what happens at the program. The facility administrator reported each month the student council gathers and youth discuss concerns and recommendations.

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 regarding establishing a community support group or advisory board to meet at least once quarterly. The program is separated in two annual compliance reviews but the advisory board is one for both sections. Since the last annual compliance review in January 2020, the program only required one advisory board meeting, which was held on February 12, 2020. The next meeting is scheduled in June 2020. The program maintains minutes and sign-in logs of the quarterly advisory board meetings which the program staff, community staff, faith based, and education. were in attendance. A review of documentation indicated the program solicited involvement from local law enforcement, judiciary community, community partners, business community, former parent/guardian whose child was previously involved in the juvenile justice system, and school board or district. During the annual

compliance review period, the program provided documentation of soliciting a Lesbian, Gay, Bisexual, Transsexual, Queer, and Intersex (LGBTQI) community member. The facility administrator (FA) reported the advisory board meets quarterly. Invitations are mailed to all required parties. The program is currently working on increasing attendance of members. The members are involved in different projects such as the greenhouse, animal program, and dog training/foster program. The program will continue to solicit new members through letters and email correspondence. A board member was interviewed and reported being a member of the advisory board for approximately a year and never missed a meeting until the COVID-19 pandemic. The board member reported the board discusses topics related to family involvement, education, and soliciting new members. The board member also stated the board has been beneficial to the program.

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 outlining the programs planning process. The program reviews annual reports during staff meetings in order to inform staff of the results. The program conducts monthly all staff, master control, and supervisor meetings and daily management meetings to keep staff informed and provide staff opportunities to give feedback on various topics. The staff meetings are held monthly and include all staff positions, as evident by the staff meeting sign-in sheets. The program distributed surveys to parent/guardians and youth in February, March, and April 2020. The survey questions are about safety and concerns regarding the provision of treatment services.

The program has several initiatives in place to build staff morale and minimize staff turnover. The program has a staff morale committee to establish ideas on how to build morale and teamwork for staff. The staff can participate in on-site and off-site activities to build teamwork and are able to earn chips, which are given when staff display certain criteria such as doing things above and beyond their duties. The chips can be used to pick prizes which are given during monthly staff meetings. The facility administrator (FA) reported full-time equivalent (FTE) and overtime reports are reviewed and the program has a morale committee. The program uses internal reports, Comprehensive Accountability Report (CAR) report, and surveys to help with program planning and assessment purposes. The results of the surveys and annual reports are discussed at the next staff meeting after receiving the results. The FA reported the program conducts monthly meetings for all staff, supervisors, and master control. The program conducts daily management meeting which are attended by all administration staff. All five interviewed staff indicated staff meetings are held daily and during the meeting; topics discussed include safety and security, new intakes, alerts, drills, and observations of previous shifts. Each of the five staff reported being briefed on annual reports and surveys and believe communication is good among staff because there is an “open door” policy to speak to administration.

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 outlining the evaluation of staff performance. For each position including volunteers, there is a job description and performance standards. Staff sign and date their specific job description upon hire and is maintained in each staff’s personnel records. Each of the five reviewed staff job descriptions included all required information and the performance standards were clearly identified. All five reviewed staff records maintained an

annual performance evaluation for the past two years. Each of the annual performance evaluations were signed by the staff, supervisor ,and administration. The facility administrator (FA) reported each year staff receive an annual evaluation which is completed by the assistant FA and unit manager. The annual evaluation is reviewed with each staff. Each of the five interviewed staff reported receiving an annual evaluation.

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

The program has a policy and procedures to promote activities for youth through recreation and leisure activities. The program has a contract to employ a recreation therapist with a bachelor's-level degree in therapeutic recreation. However, the program hired a staff with an associate of arts degree. The program recognized the error and advertised the position during the annual compliance review. The program's weekly schedule has recreation to be held at least one hour a day. A review of the logbooks for the past six months confirmed youth receive large muscle exercise daily, as required. The youth participate in football, soccer, and basketball. Leisure time activities include the youth playing cards and board games Youth can provide feedback verbally during student council meetings and surveys regarding recreation activities.

Staff and youth interviews indicated youth have one hour of recreation time daily including both outdoor and indoor activities.

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 regarding initial contact with each parent/guardian within twenty-four hours by telephone and written notification of parent/guardian, court, and juvenile probation officer (JPO) within forty-eight hours of admission. A review of five youth records found documentation in all records, verifying the appropriate notifications were completed within the established time frames.

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 regarding youth orientation process. The orientation process is conducted for each youth on the date of admission to the program. Five youth records were reviewed and found documentation in all which verified orientation was conducted on the day of admission. The orientation covered the following topics to include available services, program schedule, youth expectations, behavioral management system, medical and mental health services, Florida Abuse Hotline, zero-tolerance regarding sexual misconduct, performance planning, dress code/hygiene, community access, grievance procedures, emergency procedures, and a facility tour. A copy of the daily schedule is posted on the bulletin boards in each housing module. All five reviewed youth records had documentation acknowledging receipt of a handbook, contraband form, and orientation form. The youth handbook contained information on all required topics which are also covered in orientation to include expectations for release, procedures on visitation, mail and use of the telephone, medical topics, assignment to a living unit and room, and treatment team. Due to the COVID-19 pandemic, there were no admissions to the program during the annual compliance review; therefore, a program orientation was not observed. Five interviewed youth indicated each youth was given an orientation within twenty-four hours of admission into the program.

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

The program has a policy and procedures regarding written consent for youth eighteen years or older.

Two of the five reviewed youth records were youth over the age of eighteen; therefore, one additional record was requested. A review of the records confirmed each applicable record contained the appropriate signed consent forms.

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

The program has a policy and procedures outlining the classification process. Five youth records were reviewed and each indicated the initial classification was conducted on the day of admission. The case manager verified the classification process takes place on the date of admission. The classification documents identified several factors used in assignment of living quarters such as the youth's physical characteristics and age, maturity level, special needs, history of violence, gang affiliation, criminal behavior, vulnerability to victimization, and sexual aggression. A new Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) form was completed and entered in the Department's Juvenile Justice Information System (JJIS) prior to each youth's room assignment. The classification includes identification or suspected risk factors such as suicide, medical, escape, and any other security risk. A review of JJIS verified the appropriate alerts were entered. Reassessments were completed prior to increasing the youth's privileges, assignment to work projects or activities involving tools, as well as any off-campus activities. Due to the COVID-19 pandemic, off-campus activities have been suspended until further notice. An interview with the facility administrator (FA) indicated the classification meeting takes place during the intake process. During the meeting, factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning youth to a living unit/sleeping room.

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 regarding gang identification outlining notification to law enforcement.

Three of the five reviewed youth records were applicable for youth identified or suspected as gang members. A review of the three applicable records confirmed the notification of local law enforcement as well as the notification of law enforcement in each youth's home jurisdiction. All three applicable youth case management records documented the local school district and each youth's assigned juvenile probation officer (JPO) were notified of each youth admitted as a gang member or suspected gang involvement. A review of the Department's Juvenile Justice Information System (JJIS) confirmed alerts regarding gang involvement were entered 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 outlining gang prevention and intervention efforts. Three of the five reviewed youth records reviewed were applicable for youth identified or suspected as gang members. The three applicable records indicated each youth was participating in gang prevention and intervention groups since their arrival at the program. The performance plans included goals or objectives relating to gang intervention strategies to be completed prior to each youth's release from the program. The program utilizes the Phoenix Resources - New Freedom Programming and Impact of Crime (IOC) lesson plans for gang prevention/awareness instructional classes.

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

The program has a policy and procedures regarding the completion of an initial Residential Assessment for Youth (RAY) for each youth in the program. The assessments are required to be completed within thirty days of admission. A review of five youth records found the RAY was completed within thirty days of each youth's admission and were maintained in the Department's Juvenile Justice Information System (JJIS). Three of the five youth had been in the program over ninety days and required reassessments. The reassessments were completed within ninety days of the initial assessment, as required. JJIS did not show the reassessment for two of the applicable youth but hard copies of the reassessments were in each youth record. The case management staff indicated the program had issues with JJIS not working.

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 regarding the Youth Needs Assessment Summary completion (YNAS). A total of five youth records were reviewed and each contained a YNAS, which was completed within thirty days of admission and documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures for the development of performance plans and goals. A review of five youth records found each contained an Individualized Performance Plan (IPP) developed after the initial assessment, which is completed upon each youth's admission. The plans were all developed within thirty days of admission to the program. The IPP was signed by each youth, treatment team leader, and all staff participating in the plan and goal development meeting. All five records contained documentation verifying a copy of the plan was mailed to each youth's parent/guardian. The individual goals in each plan were based on each youth's prioritized needs reflecting risk and protective factors. All IPPs addressed each youth's top three criminogenic needs and included specific delinquency interventions to decrease criminogenic risk factors. Each plan included target court ordered sanctions, transition activities, detailing the responsibilities of each youth and staff as well as target dates for goal completion for each activity. All five youth records contained documentation indicating a letter and the performance plan were mailed to the committing court, juvenile probation officer (JPO), and the parent/guardian within ten working days of the plan being completed. Each of the five interviewed youth indicated they participated in the development of the performance plan, were aware of their goals, and indicated they received a copy of their performance plans.

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

The program has a policy and procedures regarding performance plan revisions. Five youth records were reviewed for performance plan revisions, and all but one was applicable. The one non-applicable youth had not been in the program long enough for a revision to be completed. Each of the applicable records had a performance plan revision as warranted by the results of the Residential Assessment for Youth (RAY), newly acquired information, youth demonstrated progress, or lack thereof, toward completion of a goal and where applicable revisions needed to facilitate transition activities during the last sixty days.

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 regarding performance summaries and transmittals. A review of five youth records found four were applicable for ninety-day performance summaries. The remaining record found, the youth had not been in the program ninety days. Each of the four applicable records contained performance summaries completed at intervals of at least every ninety days following the signing of the initial performance plan. All reviewed summaries contained the status of each performance goal, treatment progress, academic grades, behavior, and level of motivation/readiness to change. The summaries also included interaction with peers and staff, overall behavior adjustment to the program, significant positive and negative events, and where applicable justification for release. Copies of the performance summaries were provided to each youth. The performance summaries were signed by the treatment team leader, staff member preparing the summary, program director, and each youth. Each youth could read and add comments prior to signing the summary. The chronological notes in each youth record indicated a copy of the performance summary was sent to the committing court, the juvenile probation officer (JPO), and the parent/guardian within ten business days. Three closed records were reviewed and each had the original discharge summaries submitted to each youth's JPO along with the Pre-Release Notification (PRN), at least forty-five days prior to each youth's release and. a copy was maintained in each record. All three records had documentation of written notification sent to the parent/guardian upon receipt of the PRN approval. The Department's Juvenile Justice Information System (JJIS) indicated each youth had an Exit Residential Assessment for Youth (R-RAY) completed by the program after the PRN was approved. All three records indicated the performance summary, transition plan, and any other reports completed while each youth was at the program were provided to the JPO upon each youth's release. All five youth interviews indicated they each received a copy of their performance summaries.

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

The program has a policy and procedures regarding parent/guardian involvement in case management services. A review of all five youth records chronological notes and copies of correspondence verified the program mails pertinent documents to the parent/guardian upon admission which outlines the program and the importance of family involvement throughout the process. This includes the assessment process, the development of the performance plan, progress reviews, treatment team meetings, and transition/release planning as well as to provide the opportunity to each parent/guardian to participate by phone/video conference or give verbal/written input.

Due to the COVID-19 pandemic, participation of the treatment team meeting was by telephone. The annual review team participated in a total of three treatment teams by telephone during the week of the annual compliance review. During the treatment team meeting, each youth's parent/guardian and juvenile probation officer (JPO) were contacted by telephone for each meeting. An interview with the facility administrator (FA) confirmed the parent/guardian is provided a handbook to help familiarize them with the program. They are also contacted and encouraged to take part in their child's progress by participating in treatment teams, family meetings/counseling sessions, visitation, and family days. Four of five youth interviews reported each parent/guardian is involved in treatment team meetings. The remaining youth was over eighteen years of age; however, the case manager attended the meetings, as the youth had aged out of the foster care system.

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 which governs the members of the treatment team. A review of five youth records indicated the program conducts treatment team meetings as required. The youth, team leader, administrative representative, living unit representative, treatment staff, educational staff, parent/guardian, juvenile probation officer (JPO), the psychiatrist, and others as deemed necessary were present or participated by telephone. Each record indicated the JPO, parent/guardian, and any other pertinent parties were invited and encouraged through advanced notification to participate or given the opportunity to provide input. Due to the COVID-19 pandemic, the education staff are not at the center. The academic progress is sent to the case manager weekly by the lead teacher to be included in the treatment team.

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 regarding incorporation of other plans into performance plans. A review of five youth records documented the incorporation of other plans into the performance plan. Each record contained academic plans as well as separate treatment plans which were included in each 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 outlining bi-weekly treatment team meetings for both formal and informal meetings. A review of five youth records documented the program conducts formal treatment team meetings at a minimum of every thirty days and informal meetings on a bi-weekly basis, once a month. All treatment team meeting reports formal and informal, contained each youth's name, date of the review, team members attending and any comments,

a synopsis of each youth's progress, performance plan revisions, progress on goals, positive or negative behavior issues, and those resulting in physical intervention. Furthermore, the form includes each youth was provided an opportunity to demonstrate skills, treatment progress, and Residential Assessment for Youth (RAY) results. Due to the COVID-19 pandemic, most of the treatment team members participated by telephone. A total of three treatment team meetings were held during the week of the annual compliance review period. All required staff participated in the treatment team meetings and all required information was discussed in each. Five youth interviews indicated youth are given the opportunity during treatment team meetings to provide input and demonstrate any skills they have learned in the program. Some examples of these skills were improvement on school grades, coping skills, and working well with others.

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

The program has a policy and procedures in place regarding career education. Career education programming is provided by the Osceola County Schools. The program provides type three career education programming and offers vocational certificates to youth fifteen years of age and older. The vocational and career education programs are appropriate for age and educational abilities for the youth in the program, as well as the length of stay in the program. A total of three closed youth records were reviewed and contained samples of completed employment applications, résumé, information regarding home county career source centers, and appropriate documents essential to assist in obtaining employment. All three records documented each youth's parent/guardian were made aware of the vocational plan for each youth. The facility administrator (FA) indicated they are currently providing agriculture and culinary arts classes through Osceola County Schools. An interview with the lead teacher confirmed youth participate in an initial career interest interview and work through the Florida website, My Career Shines which provides career interest inventories and information about possible future careers. The guidance counselor works to provide students information about various careers, as does all educational staff. Career interests are merged in instructional classroom studies.

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

The program has a block schedule for classes which consist of three, two-hour blocks per day, alternating classes daily which provided a total of thirty hours of classroom instruction weekly prior to the COVID-19 pandemic. The school's calendar is spread out over a twelve-month period, providing a minimum of the 250-days of instructions with ten or less days used for teacher planning or training. A review of six randomly selected dates since the last annual compliance review, indicated the activity schedule and logbook documented minimal interference or deviation of educational instruction. An interview with the facility administrator (FA) confirmed due to the COVID-19 pandemic, youth are currently attending class for three hours a day, with lesson plans provided by the teachers and supervision by program staff. The program director advised teachers will be returning part-time the week of May 18, 2020 and back to a full-time schedule the following week. Due to the COVID-19 pandemic and in accordance with the Governor's restrictions, the Osceola County School Board is currently

prohibiting all teachers from entering the program. Five youth were interviewed and each advised there is no interruption when they are attending class.

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

The program has a policy and procedures in place regarding education transition plans. Three closed youth records were reviewed and each included the development of an education transition plan based on each youth's post release goals. All required key personnel were included and the plan was developed with each youth and program, education, and aftercare staff. Guidance regarding the youth's educational needs is provided by the Osceola County Schools System. Each of the three youth education transition plans addressed services and intervention as well as, recommended education placement based on each youth's assessed educational needs and post-release education plans. The plan placed specific monitoring responsibilities on individuals responsible for the reintegration and coordination of the provision of support services. Each youth had employability as a transition goal and the education transition plan included provisions for continuation of education and/or employment, a sample employment application and a résumé, valid Florida identification, a calendar with a follow-up appointment with the Career Source Center, and documents such as birth certificates and social security cards to assist in obtaining employment upon leaving the program. Each record documented each youth's case manager and parent/guardian were aware of the plan, documents, and post-release discharge plans.

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

The program has a policy and procedures addressing transition planning, conference, and Community Re-Entry Team (CRT). A review of three closed youth records verified each contained transition planning, transition conferences, and CRT meetings were conducted. The three youth records contained documentation confirming a transition conference was held at least sixty days prior to the targeted release date and was attended by each youth, treatment team leader, program director or designee, case manager, educational staff, juvenile probation officer (JPO), and parent/guardian. The JPO and parent/guardian were contacted by telephone. In all three youth records, the treatment team leader invited and encouraged participation of the required parties through advanced notification. During the transition conference, the participants

reviewed transition activities on each of the performance plans, revised the plans, identified additional transition activities and target completion dates, as well as persons responsible for completion. The treatment team leader obtained signatures of all attendees and sent a copy to those who were not present such as the JPO and parent/guardian who have responsibilities for goal completion. Documentation indicated each of the plans were electronically submitted to the JPO. A CRT meeting was conducted for each of the three youth prior to release. Each youth, case manager, and JPO participated and a copy of the outlook invite is maintained in each record.

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 addressing the exit portfolio completion. A review of three closed youth records confirmed all exit portfolios were completed for each youth released and the exit portfolio was discussed and initiated during the transition conference. Each record contained the youth's transition plan, a calendar with upcoming appointments, birth certificate, a state issued identification card, social security card, educational/vocational certificates, educational records/transcripts, résumé, and sample employment application. The exit portfolio confirmed the exit conference and a Receipt of Exit Portfolio form were signed by each youth and received a copy. Documentation in all three records indicated the exit portfolio was forwarded to the juvenile probation officer (JPO).

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 addressing exit conferences. Three closed youth records were reviewed for documentation of an exit conference. All three records indicated the conference was conducted after the program notified the juvenile probation officer (JPO) of each youth's release and at least fourteen days prior to release. Each conference was attended by each youth, treatment team leader, education staff, JPO, and parent/guardian. The documentation was maintained with signatures and names of all attendees, as well as a summary of pending transition goals. The JPO and parent/guardian participated by telephone. During each exit conference, the status of transition activities was reviewed and plans were finalized for each youth's release. The Department's Juvenile Justice Information System (JJIS) date of admission and date of termination matched those in each youth records. In all three records, the exit conference was separate from the Community Re-Entry Team meeting.

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 policy and procedures addressing the designated mental health clinician authority (DMHCA). The program has a single licensed mental health clinician (LMHC) serving as the DMHCA in the position of the clinical director. The position description indicated the DMHCA serves as a standing member of the facility's management team and shares responsibility for all programmatic, operational, clinical, fiscal, and employee related matters. As a full-time staff member, the DMHCA maintains supervision of all clinical time-lines, is the contact person for all clinical matters with outside agencies, and supervises the licensed mental health therapist and all the non-licensed therapists. Although, the DMHCA does not carry a caseload, a review of documentation revealed the DMHCA provides direct care services such as Assessment of Suicide Risk (ASR), brief behavioral clinical interview on admission, Massachusetts Youth Screening Inventory - Second Version (MAYSI-2), and biopsychosocial mental health, and substance abuse assessments. An interview with the DMHCA revealed the DMHCA provides oversight of the implementation and provision of mental health treatment services including clinical supervision of the licensed and non-licensed clinical staff. Provision of services is monitored by daily group sign-in sheet review, billing documentation, fidelity monitoring, and case consultation. The DMHCA personally provides crisis intervention, individual, group and family therapy, completion of intake procedures, and supportive counseling services. The DMHCA meets with the psychiatrist weekly and participates in formal treatment team meetings.

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 addressing licensed clinical staff. In addition to the designated mental health clinician authority (DMHCA) the program has two full-time licensed mental health counselors (LMHC). The program has a corporate regional clinical director who is also a LMHC who provided services as needed during the review period. The program has a contract with a psychiatrist and a psychologist who provides direct care services to youth. Each of the five mental health professionals providing services, including the DMHCA, holds a clear and active license with the Department of Health, Bureau of Medical Quality Assurance. Each of the three mental health clinician's license expires on March 31, 2021. The psychiatrist's license expires on January 31, 2022 and the psychologist's license expires on January 31, 2022. The

program also has a contract with a behavior analyst (BA) who holds credentials as a board certified behavior analyst (BCBA) whose certificate is clear and active through June 30, 2021.

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

The program has four non-licensed clinicians on staff in which two hold credentials as registered mental health counselor intern (RMCHI) with the Department of Health, Medical Quality Assurance. The remaining two non-licensed clinicians holds master's-level degree from an accredited university in a human services field. The program holds a Chapter 397 license to provide substance abuse services to the youth in the program with an expiration date of April 1, 2021. The program has a policy and procedures addressing non-licensed clinicians, indicating licensed mental health staff shall ensure non-licensed 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 mental health staff shall receive direct supervision from a licensed professional once a week and staff who perform Assessments of Suicide Risk (ASR) shall have twenty-hours of training and experience in assessing suicide risk co-facilitated by a licensed clinical staff. The program provided documentation of training in ASR for three non-licensed clinicians, including co-facilitated assessments. However, the three non-licensed clinicians did not complete the training due to the program not having enough youth requiring an ASR for the training to be completed. The program maintains documentation the licensed clinician provides weekly clinical supervision to the non-licensed clinicians as well as the case managers and recreational therapist. A review of the supervision notes revealed each weekly review included individual case reviews, directions by the licensed clinician, and training. Each week documented the date and either the beginning/ending time or the duration of the supervision, supported by the attendees and signatures of all staff, including the licensed clinician directing the supervision. There were no gaps in the weekly supervision.

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

The program has a policy and procedures addressing mental health and substance abuse admission screening. This includes staff training in mental health and substance abuse issues, administration of required screening instruments, and the standardized process for referral of youth in need of further evaluation. The screening procedures for each youth includes the program initiates a records review sheet to include each youth's applicable Positive Achievement Change Tool (PACT) or Community Assessment Tool (CAT) assessment, Face Sheet, Pre-Disposition Report (PDR), Department's pre-commitment comprehensive mental health evaluation, intake Massachusetts Youth Screening Inventory - Second Version (MAYSI-2), and intake Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). The records review sheet includes a space for signature confirming the review for the clinical director, therapist, case manager, transitional case manager, facility

administrator/designee, nurse, and other personnel. Each of the five reviewed youth records contained a review sheet filled out by all parties indicating each staff reviewed the documents itemized on the records review sheet. . The screening process includes if a youth screens with indicators for suicide, the youth receives a referral for an Assessment for Suicide Risk (ASR) within twenty-four hours, an alert is generated in the Department's Juvenile Justice Information System (JJIS), precautionary observation begins, and notifications are made to mental health and the program director/designee. Four of the five MAYSI-2 screenings were completed by the licensed clinician and referred to the assigned non-licensed clinician. One was completed by a case manager and referred to the assigned mental health clinician. All five reviewed youth received a referral to a mental health professional, received an ASR by a licensed clinician, a consultation documented on each ASR, as well as the referral. Reviewed documentation revealed one of the five youth required a referral for an ASR and the required process was carried out.

Each of the five reviewed records documented the clinical director or other licensed clinician completed a Brief Behavioral Health Evaluation upon admission and clinical staff completed the following screening tools: MAYSI-2, ASR, Suicide Probability Scale (SPS), Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), and VSAB. Four of the five MAYSI-2 screenings were scored on JJIS at admission and the remaining one was scored in JJIS three days later. Interviews with program staff indicated the late scoring on JJIS was an oversight. All five youth received a referral for a comprehensive evaluation. An interview with administration revealed the admission screening process includes administration of the MAYSI-2, ASR, and SASSI-A2.

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

The program has a policy and procedures addressing mental health and substance abuse comprehensive evaluations. Procedures include the mental health and substance abuse evaluations completed within thirty days of referral or admission.

The five reviewed records each documented the clinical director or other licensed clinician completed a Brief Behavioral Health Evaluation upon admission. Clinical staff completed the Massachusetts Youth Screening Inventory - Second Version (MAYSI-2), Assessment of Suicide Risk (ASR), Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Beck Depression Inventory (BDI), The Strengths Needs and Abilities Profile (SNAP), Kaufman Brief Intelligence Test- second edition (KBIT-2), and Learning Styles Inventory (LSI). Each of the five comprehensive evaluations included the findings of the assessment and the psychiatrist's completion of the psychiatric evaluation. When findings conflict with the Department's pre-commitment evaluation, the reasons were documented.

Each of the five comprehensive evaluations included the required elements such as Identifying Information, reason for evaluation, relevant background information, history of abuse and trauma, behavioral observations, mental status examination, procedures administered, patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, risk factors of continued use, discussion of findings, diagnostic impression including diagnoses, and recommendations. Each comprehensive evaluation addressed the original referral reason. Each

of the five comprehensive evaluations was completed within thirty days of admission. One of the evaluations was completed by the licensed clinician. The remaining four evaluations were completed by the non-licensed clinician and reviewed by licensed clinician within ten days. All five records included a substance abuse services consent form.

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

The program has a policy and procedures addressing mental health and substance abuse treatment. Each youth was assigned a treatment team consisting of representatives of administration, education, vocational training, medical staff, mental health staff, living unit representative, youth, and parent/guardian. Each treatment team assignment contained the signatures of the applicable representatives. Several records documented changes in assigned members of the treatment team confirmed by a completely new treatment team signature page. Each of the five youth signed a Substance Abuse Consent and Release form and each record contained a properly executed Authorization for Evaluation and Treatment (AET).

Mental health and substance abuse treatment services were provided by licensed/qualified professional staff or non-licensed clinical staff working under supervision of a licensed clinician. Services were provided in accordance with each youth's initial or individualized treatment plan including individual, family, and group therapy. Mental health group therapy is limited to ten youth and substance abuse group therapy sessions are limited to fifteen or less youth. Mental health and substance abuse treatment notes were documented on a form which contained all required elements. Each of the five youth also received psychosocial skills training addressing specific symptoms identified in the individualized treatment plan.

Only master's-level clinicians working under a licensed clinician provided mental health and substance abuse group therapy and substance abuse education. Five staff were interviewed and asked if they provided mental health or substance abuse groups to youth. None of the five staff indicated they facilitated mental health or substance abuse groups to youth. All five youth interviews indicated they participated in groups and received specialized therapy. Four of the five youth specified they were receiving individualized and group therapy.
An interview with the clinical director revealed the program provides mental health overlay services.

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

The program has a policy and procedures addressing treatment and discharge planning. The process includes each youth receives an initial treatment plan on the day of admission and an individualized treatment plan within thirty days of admission. Treatment plans are reviewed during the monthly treatment team review process. A mental health and substance abuse treatment discharge summary is developed with the parent/guardian and youth and reviewed at the exit conference meeting.

A review of five youth records revealed each youth received an initial treatment plan on the day of admission. Each initial treatment plan included the reason for the mental health and substance abuse treatment, initial diagnostic impressions, initial treatment methods, goals, and objectives. Two youth were admitted with prescribed psychotropic medications. Each of the two youth's initial treatment plans included the medication prescribed and the plan for each youth to see the psychiatrist within fourteen days; however, neither of the two youth's initial treatment plans included the frequency of medication management. Each of the initial treatment plans was signed by the clinician, all treatment team members, and youth including the licensed clinician within ten days of completion of the initial treatment team. A review of five youth records revealed each youth had an individualized mental health and substance abuse treatment plan developed within thirty days of the initiation of treatment. Each plan was developed on the appropriate form and signed by the mental health clinician and all treatment team members who participated in development of the plan. The licensed clinician reviewed and signed the individualized plan within ten days of completion the initial treatment team. Two applicable plans included psychiatric services including psychotropic medication and frequency of monitoring. Individualized treatment plan reviews were completed on a form to include all required information. A review of the required thirty-eight monthly treatment plan in the five youth records were documented as completed within the required time frame. Two youth records contained treatment plan revisions completed when significant changes occurred. One treatment plan was revised due to the youth beginning to take psychotropic medication. The treatment plan revision documented the medication and frequency of medication management. The remaining treatment plan revision documented an additional diagnosis and appropriate goals and interventions. The progress notes documented each of the five youth received the services as stipulated by the treatment plan.

None of the five youth records included a discharge summary. Three additional records were reviewed specifically for discharge planning. Each of the three youth records contained a mental health and substance abuse discharge summary developed prior to the exit conference and documented on the required Department form. Each discharge summary included recommendation for services needed in order to maintain the positive improvement each youth made while in the program. Documentation supported the parent/guardian was invited to the

exit conference and the summary was discussed with all parties. Documentation also indicated a copy was provided to the juvenile probation officer (JPO), youth, and parent/guardian upon discharge.

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

The program has a policy and procedures addressing specialized treatment services. The program provides specialized mental health overlay services (MHOS). The program provides individual, group, or family therapy five days a week. There are daily therapeutic activities such as psychosocial skills training, psycho-education, and supportive counseling provided by a mental health clinical staff. Reviewed documentation supports the program consistently delivered Skill Streaming the Adolescent twice a week, Trauma-Focused Cognitive Behavioral Therapy (CBT) three times a week, and both Teen Relationships and Young Men's Work (YMW) once a week.

The psychiatrist is on-site once a week and provides psychiatric evaluations upon admission and psychotropic medication monitoring every thirty days for applicable youth. The psychiatrist is available for consultation seven days a week, twenty-four hours a day. Youth with co-occurring substance abuse disorders receive substance abuse services. The program has licensed mental health professionals on-site at least five days a week. The program has arranged for a contracted psychologist to provide services, as needed. Counselor caseloads do not exceed sixteen youth.

An interview with administration revealed the program's specialized services are mental health overlay services (MHOS).

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

The program has a policy and procedures addressing provision of psychiatric services. The program contracts with a licensed psychiatrist who provides psychiatric services on-site once a week including evaluation, medication management, and consultation services. The psychiatrist provides psychiatric evaluations upon admission for each youth, psychotropic medication monitoring for applicable youth every thirty days, and is available for consultation seven days a week, twenty-four hours a day. The psychiatrist holds a clear and active license which expires on January 31, 2022.

An interview with the psychiatrist revealed they are on-site weekly, conducts psychiatric evaluations within fourteen days of a youth's admission, provides monthly medication management, participates in quarterly interdisciplinary meetings, is on-call twenty-four hours a day, seven days a week for consultation, and conducts evaluations for youth with referrals, as

needed. The psychiatrist confirms meeting with the designated mental health clinician authority every thirty days or less to discuss psychiatric services and participates in formal treatment team meetings face-to-face for all youth on psychotropic medication every thirty days. The psychiatrist indicated they have no healthcare concerns at the program. A review of five youth records revealed each youth received a psychiatric evaluation within a week of admission containing all required elements. Two of the youth were on prescribed psychotropic medications upon admission. The psychiatrist was notified by telephone of the admissions and authorized continuation of the medication. Following one youth's initial psychiatric evaluation, the psychiatrist discontinued the medication at the youth's request. A couple of months following admission, a third youth was referred to the psychiatrist for additional psychiatric evaluation and consideration of psychopharmacological intervention. The psychiatrist performed an additional evaluation and prescribed medication. In each case, the psychiatric evaluation was documented on the Clinical Psychotropic Progress Note (CPPN) including page three. Each youth on psychotropic medication consistently received medication management appointments with the psychiatrist every thirty days. One youth's diagnosis was modified by the psychiatrist during the course of treatment. The mental health and substance abuse treatment plan was updated to reflect the added diagnosis prior to the next treatment team meeting.

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 addressing the suicide prevention plan. The program has a suicide prevention plan in place which was last reviewed on January 13, 2020. The plan included procedures for identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process. A copy of the suicide prevention plan was maintained in a binder in master control. Step down to standard from close supervision must be documented in writing by the clinical director or designee on the follow-up assessment of suicide risk (ASR), facility logbook, and documented in each youth's progress notes.

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 has a policy and procedures addressing suicide prevention services. A review of five youth records revealed each youth received an initial Assessment of Suicide Risk (ASR) at admission. Four of the five youth were stepped down to standard supervision as a result of the recommendation of the ASR. The fifth youth was recommended for constant supervision and remained on precautionary observation. Each of the five ASRs was completed by a licensed

mental health clinician on the day of admission. An interview with staff revealed one other youth was placed on precautionary observation/constant supervision within the last twelve months. A review of the additional applicable youth's record revealed the youth was referred to the mental health clinician and received an ASR within twenty-four hours of referral. The youth was maintained on precautionary observation/constant supervision as a result of recommendations of the ASR. Each of the two applicable youth received a suicide alert posted in the Department's Juvenile Justice Information System (JJIS), were continued on constant supervision until a follow-up ASR was completed recommending step-down to close supervision, in accordance with the program's suicide prevention plan. Each of the two applicable instances were documented on the ASR, a conference between the licensed mental health staff and the program director/designee, notification of the parent/guardian, and juvenile probation officer (JPO) including recommendations for step-down to standard supervision in accordance with the program's policy.

A review of documentation indicated each applicable youth was allowed to participate in certain activities, a designated safe housing area was identified, and activities were not limited to an individual cell/sleeping room. The logbooks consistently documented the status of youth on precautionary observation, instructions to staff, and specific times the status changed including the authority making the change. There was documentation licensed clinical staff were in the process of training non-licensed staff in completion of ASRs. However, none of the non-licensed staff had completed the twenty hours of training including five co-facilitated ASRs. The actual date/time of the consultation between the clinician and the program administrator/designee was consistently documented on the ASR.

The program has three suicide response kits, one in master control and one each in the two sub-controls. Each kit contained the required tools. The program has an established review process for every serious suicide attempt or serious self-inflicted injury and mortality review for a completed suicide. The process included all required elements.

Five staff were interviewed regarding their responsibility if a youth expresses suicidal thoughts. All five staff indicated they should notify mental health, search each youth and room for sharp objects, and monitor each youth constantly in sight and sound supervision. One staff indicated the supervision of youth must be documented. All five staff identified the location of the suicide response kits are in master control and in the sub-control.

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

The program has a policy and procedures addressing suicide precaution observation logs. One of the five reviewed youth records were applicable for suicide precautionary logs. The program was only able to provide one additional sample for the annual compliance review period. Both suicide precautionary logs for each youth were consistently maintained with documentation of monitoring completed every thirty minutes. Each log identified safe housing areas and warning signs to be aware of. Neither of the logs documented an occasion in which each youth being monitored had exhibited a warning sign; however, there are procedures in place to notify the supervisor and mental health staff if warning signs were present. All suicide precautionary logs were signed by each shift supervisor and the mental health clinician daily.

During the annual compliance review period, only one youth remained in the program who had been placed on precautionary observation. The youth was interviewed regarding how staff monitored him during this time. The youth indicated staff remained with the youth at all times and was never left alone for any period of time.

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 addressing suicide prevention training. A review of five staff records revealed each staff had received six hours of suicide prevention training including two hours of the Department's Learning and Management System (SkillPro) and four hours of instructor-led training.

The program conducted quarterly mock suicide drills on each of the three shifts.. A review of thirty-four staff training records revealed each staff participated in at least two mock suicide prevention training drills a year. A review of mock suicide drill sheets contained sign-in sheets, date and time of the drill, scenario, response to the presentation, use of the suicide rescue tool, practice of cardio-pulmonary resuscitation (CPR), and use of the automated external defibrillator (AED) as well as first aid practices.

An interview with administration revealed the program conducts mock suicide drills for staff monthly on all shifts and are reviewed at all team meetings.

Five staff were interviewed regarding the suicide response kits. All five indicated the suicide kits are maintained in master control and sub-control.

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 addressing mental health crisis intervention services. The program has a mental health crisis intervention plan separate from the emergency mental health and substance abuse services plan in place. The plan includes notification, an alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The program's plan received an annual review on January 13, 2020. The crisis assessment plan requires the use of the Department form or one which contains all the information in the Department's form. There were no instances utilizing the Department's or program's form during the annual compliance review period.

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

The program has a policy and procedures addressing crisis assessments. Interviews with staff indicated there were no occasions in which a crisis assessment was completed. A review of youth records and logbooks did not reveal any instances in which a crisis assessment should have been completed. However, the program has a process in place to provide crisis assessments when the situation requires one, including mental health alert, levels of supervision, oversight by management, and involvement of mental health clinical staff.

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

The program has a policy and procedures addressing emergency mental health and substance abuse services. The program has an emergency mental health and substance abuse services plan separate from the crisis intervention plan in place. The plan includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services including Baker Act and Marchman Act, documentation, training, mock drills, and review. The plan received an annual review 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 has a policy and procedures addressing Baker and Marchman Acts. The program did not utilize a Baker Act or Marchman Act procedure during this annual compliance 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 policy and procedures addressing the designated health authority (DHA) or designee is responsible for communication with staff regarding youth medical needs and having availability for consultation by electronic means twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care.

The program's DHA is a medical doctor who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. The license is clear and active and expires on January 31, 2021. The physician's specialty training was in family practice and a review of the last six months of the DHA sign-in logs, indicated the DHA was on-site at least once a week. If the DHA was on vacation or during scheduled absences, coverage was provided by a doctor of equal licensure.

An interview with the DHA indicated, the DHA is on-site weekly and on-call twenty-four hours a day, seven days a week. The DHA completes comprehensive physical assessments (CPA) for each youth, periodic evaluations, conducts sick call follow-up if needed, reviews off-site visits, and is involved in policy and procedure development.

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 a policy and procedures addressing the facilities healthcare services. The designated health authority (DHA) and the facility administrator (FA) signed and dated all respective treatment protocols and facility operating procedures (FOPs) on an annual basis. The DHA writes and approves 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 review. The program had one new healthcare staff since the last annual compliance review. A review of the registered nurse (RN) comprehensive clinical orientation training included the Department's healthcare policies and procedures.

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

The program has a policy and procedures addressing the use of the Authority for Evaluation and Treatment (AET). A review of five youth records indicated four had a legible copy of an AET with the word "COPY" stamped on the AET and maintained in the individual healthcare record (IHCR). One youth was in the care of the Department of Children and Families (DCF) when entering the program and a court order was maintained in the IHCR allowing the program to provide medical services. When the youth turned eighteen years of age, the youth signed an AET for adults which was maintained in the record. In all five applicable records, the completed

parental notifications were filed behind the AET/court order in the IHCR. The nursing staff interview indicated the program's policy for obtaining a new or current AET is to call the parent/guardian, and to notify them the program will mail an acknowledgement for consent for the AET. For youth ages eighteen or older, each youth signs a consent form.

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

The program has a policy and procedures addressing parental notification and consent. Three of the five youth records reviewed were applicable for parental notifications. In each of the three applicable records, the parental notifications included discontinuation of medications prescribed prior to each youth entering the custody of the Department, change in conditions/medication for youth with chronic conditions, and new medications. Two of the youth had parental notifications made by telephone and subsequently in writing for off-site emergency care and hospitalizations, surgeries/invasive procedures, non-routine dental procedures, and medical treatment. In all three records reviewed, written notifications were sent regardless of telephone notifications, a staff witnessed the telephone conversations, and was documented in each record. In one record, the youth was in the care of the Department of Children and Families (DCF) and had a court order maintained in the individual health care record (IHCR) allowing the program to provide medical treatment. In one of the three applicable records, a psychotropic medication was initially prescribed, discontinued or the drug dosage was significantly changed, and the parent/guardian verbal consent was documented on the Clinical Psychotropic Progress Note (CPPN). The CPPNs were sent to the parent/guardian for signature in which none were returned with signature. In all five reviewed records, the vaccinations were verified within thirty-days of each youth's admission. The interview with the nursing staff confirmed the program's process for documenting parent/guardian exemption from immunizations which involves the parent/guardian to sign an Exemption from Immunization form to be filed in each youth's IHCR. The staff stated the immunization records are obtained from Florida Shots and reviewed at the time of each youth's admission.

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

The program has a policy and procedures addressing the usage of the Facility Entry Physical Health Screening Form (FEPHS). In all five youth records, the FEPHS was completed on the date of admission by a registered nurse (RN). One of the five youth records documented the youth had a change in physical custody since arrival to the program. Two additional records were requested from the annual compliance review team and the program provided two additional youth records for review. All three applicable records confirmed each youth received a new FEPHS rescreening upon return to the program and completed by a RN.

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.	

The program has a policy and procedures addressing youth orientation. In all five records reviewed, each youth received a general care orientation on the day of admission to the program. The topics included access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process, the right to refuse care, and how it is documented. The orientation comprised of the process in the event of sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers.

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.	

The program has a policy and procedures addressing the designated health authority (DHA) or designee admission notification. In one of the five youth records reviewed, the youth was admitted to the program with a known or suspected chronic condition. Two additional records were requested but the program indicated there were no other youth admitted with chronic conditions since the last annual compliance review. In the one applicable record, a referral was made to the designated health authority (DHA) upon admission of the youth and notification was made by telephone. Documentation was found in the individual healthcare record (IHCR).

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.	

The program has a policy and procedures addressing Health Related History (HRH) . In all five youth records reviewed, a new HRH was completed on each youth's day of admission to the program. The HRH was completed by a registered nurse (RN) prior to the Comprehensive Physical Assessment (CPA). In each record, the HRH was reviewed by the designated health authority (DHA) and documented on the CPA. The nursing staff interview indicated the RN is responsible for completing the HRH at the time of each youth's admission to the program.

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

The program has a policy and procedures addressing the Comprehensive Physical Assessment and tuberculosis (TB) Screening. Reviewed documentation confirmed the program's compliance with the Centers for Disease Control (CDC) and Prevention and the Occupational Safety and Health Administration (OSHA) Standards and included tuberculosis (TB) screening.

In all five youth records reviewed, the designated health authority (DHA) completed a new Comprehensive Physical Assessment (CPA) within seven calendar days of admission on the Department form. In all records the medical grade was documented on the CPA, as well as all required information pertaining to the rule. All CPAs were completely filled out and had sections

marked with an “O” or an “X”. Any part of the exam which the youth refused or not completed was appropriately marked and contained each youth’s signature of refusal on the form. The Department’s Problem List was updated when needed and all records contained at least one verified tuberculin skin test (TST) completed within the last year. In all five records, each youth was assessed prior to placement in the general population and the results of the TST were documented on the CPA and the Infectious Communicable Disease (ICD) forms.

The nursing staff interview indicated a new CPA is completed within seven days of admission and yearly, thereafter. The process for TB screening is for a TST to be administered yearly. A chest x-ray will be ordered if the DHA deems it necessary.

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.	

The program has a policy and procedures addressing sexually transmitted infection (STI) and human immunodeficiency virus (HIV) screening. A review of five youth records documented the sexually active youth was clinically screened and evaluated for STIs and in one record the youth was referred to the designated health authority (DHA) for further evaluation. In all five records, each youth had testing ordered and performed the same day and the referral was documented on the STI form. The testing and screening results, clinical evaluation, and diagnosis were documented on the Infectious Communicable Disease (ICD) form. In all five records, each youth was offered counseling, testing, and treatment for HIV. Only one youth consented to testing. In the one applicable record, the consent form was maintained in the individual healthcare record (IHCR), the youth received the testing by a certified HIV counselor, and the HIV test results were filed in a confidential manner consistent with Florida Statute in a sealed envelope maintained in the IHCR. The program utilizes the Individual Health Education Record to document the pre-test and post-test counseling for HIV. The HIV status was not captured in the program’s internal alert system. The program has an HIV pre-test, post-test counseling and testing provider who maintains a 500/501 certification with the Department of Health (DOH). All five youth interviews indicated they can request a HIV test.

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

The program has a policy and procedures addressing procedures for sick call. When a licensed healthcare professional is not on-site, the shift supervisor shall review all sick call requests as soon as possible, within four hours after the request is submitted. Any complaint of severe pain including dental pain, shall be treated as an emergency with an immediate referral to the facility healthcare staff or the designated health authority (DHA). Emergency dental care services including complaints of severe pain, shall be provided by a licensed dentist. Sick call is conducted seven days a week. None of the five records reviewed, had a youth present with similar sick call complaints three or more times within a two-week period or complained of any severe pain which staff was unfamiliar. In all five records, each youth completed a sick call request form and placed them in a secure location inaccessible to other youth. The registered

nurse (RN) completed the sick call request form in accordance with the health services rule and was placed in the progress notes section in the individual healthcare record (IHCR) in reverse chronological order. Two of the youth had been placed on controlled observation and were seen by the nurse daily which was documented in the progress notes. Each reviewed sick call was documented on the sick call index and the sick call referral log. The program has posted sick call hours Monday through Friday at 8:00 a.m. and 2:45 p.m. and on weekends at 8:00 a.m. The modules have sick call forms for each youth to fill out and a sick call box was observed. A licensed nurse conducts sick calls. A sick call was observed during the week of the annual compliance review. The youth completed a sick call form and was escorted by a supervisor to the clinic. The RN conducted the sick call in the clinic providing privacy to the youth with staff standing outside of the room but still within view of the youth. The nurse questioned the youth regarding their name and reason why a sick call was submitted. The exam was conducted on the exam table and the youth signed the sick call form upon completion. All five staff interviews indicated the nurse responds and conducts sick call. All five youth interviews indicated they are seen immediately after completing a sick call request.

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

The program has a policy and procedures addressing episodic/first aid and emergency care. Each first aid kit shall contain a list of the required contents so staff can regularly determine whether the kit needs to be restocked. First aid kits shall be secured and clearly marked as “First Aid Kit”. Living unit staff and the shift supervisors shall regularly inventory the content of the kits to determine whether they need to be restocked. Additionally, the health services administrator (HSA) shall ensure all kits are inventoried, dated, and initialed at the time of inspection. Whenever a designated staff determines a kit needs to be restocked, the staff shall bring the kit to the HSA designee, as soon as reasonably possible. The HSA or designee shall inventory the first aid kits monthly and will restock the kits, as appropriate. The policy also incorporated the program’s episodic and emergency care procedures, including twenty-four hour emergency medical, mental health, substance abuse, and dental care availability to youth. In one of the five records reviewed, the youth received non-healthcare staff episodic care which was documented on the Department’s Report of On-site Health Care by Non-Health Care Staff form. The form included the date/time of the episodic care, the nature of the complaint, over-the-counter (OTC) medications given, treatment provided, printed name, and credentials/position of the staff providing the care. The youth received a follow-up evaluation by a licensed healthcare staff. In all five records, each youth received episodic care by a licensed nurse and was documented in the problem-oriented or standard narrative charting, containing all required elements. The Episodic Care Log documented all instances of first aid/emergency care. The program has five first-aid kits in which one is in the kitchen, one in east master control room, one in west master control room, and two are used for vehicle transport which are stored in the west master control room. Two first-aid kits used for both vehicles were reviewed. Both were fully stocked with the designated health authority (DHA) approved contents. The program has two suicide response kits with one located in the east master control room and is the second one located in the west master control room. The program maintains one automated external defibrillator (AED) in the staff break room with the procedures posted behind the AED. A self-test of the AED indicated it was in working order. The nursing staff conducts weekly checks of each AED to ensure the batteries and pads are operable as documented on a checklist and conducted as required since the last annual compliance review. The AED pads expire May 31, 2020 and the batteries expire November 30, 2021. The batteries were changed on September

20, 2019 and the pads on March 31, 2019. The emergency numbers were posted in the clinic and master control rooms, inaccessible to youth.

The program has trained non-healthcare staff in epinephrine auto injector administration. All five staff pre-service and five in-service training records indicated each staff received CPR, AED, and first aid, as required. All healthcare staff had current certification in CPR and AED. A review of medical drills for the last four quarters indicated the program completed mock emergency drills quarterly on each shift. The program conducted mock emergency drills which included CPR/AED demonstration, as required. A review of the medical drills indicated all staff participated in at least one medical drill in the last four quarters. All five staff interviews indicated they are personally allowed to call 9-1-1 if a youth has 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.	

The program has a policy and procedures addressing off-site care and referrals. In two of the five records reviewed each youth required off-site care. An additional record was requested. In all three applicable records, each youth required off-site first aid or emergency care and parental notification was made. In all three applicable records, the Summary of Off-Site Care form was utilized and filed in each individual healthcare record (IHCR), as well as the discharge and other documents, where applicable. In all three records, the designated health authority (DHA) or designee reviewed and signed all off-site care findings, instructions and information and all follow-up testing, referrals, or appointments were tracked and each youth received the appropriate care, as needed.

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.	

The program has a policy and procedures addressing chronic conditions/periodic evaluations. In one of the five youth records reviewed, the Facility Entry Physical Health Screening (FEPHS) form indicated the youth was identified as possessing a current chronic condition. The program indicated they did not have any other examples of youth entering the program with a chronic condition but were able to provide two more additional records of youth who were diagnosed with a chronic condition while at the program. In two of the three applicable records, each youth was identified as taking prescribed medication on an on-going basis. The remaining youth was undergoing treatment for a physical health condition of a Body Mass Index (BMI) of higher than thirty. All three youth were classified with medical grade five, were placed on a chronic illness list, and received a periodic evaluation within a three-month intervals. Each youth received a specialized treatment plan and the periodic evaluations were being tracked on the medical alert roster. Each periodic evaluation was conducted on-site, documented in the chronological progress note, and maintained in each individual healthcare record (IHCR). The treatment orders were written to be clearly distinguishable for the clinical staff and the Department's Problem List was updated, as required. The facility administrator (FA) interview indicated the formalized procedure with the healthcare staff is to review important medical issues during the morning meeting about each youth's information. The medical department sends daily emails with youth alerts. The nursing staff and designated health authority (DHA) interview indicated

every ninety days the DHA completes a periodic evaluation to monitor youth with chronic conditions. The DHA stated all periodic evaluations are logged and tracked to ensure all youth with a chronic condition receive the periodic evaluation, as required.

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

The program has a policy and procedures to address medication management to include the disposal of medication. Unused medications shall be returned to the pharmacy on a monthly basis. Medications shall be packed in a designated container with the Return to Pharmacy form. Stock medications shall be checked monthly to ensure the return of drugs which have expired. Controlled substances shall be destroyed by the health services administrator (HSA) or designee and consultant pharmacist on a monthly basis. Needles, syringes, and other disposable medical equipment and supplies shall be properly disposed of at least once a month. The policy indicates the reporting criteria and procedures for inventory discrepancies are to be reported to the facility administrator (FA) and investigate the situation immediately. Two of the five youth reviewed, were taking medications at the time of admission. An additional record was requested and received from the program. In the three applicable records, each youth was taking medication at the time of admission and the medication was verified prior to being accepted into the program. The prescription verification was documented on the prescription medication verification checklist and the chronological progress notes. In the three records, the designated health authority (DHA) and the psychiatrist were contacted to obtain an order to resume the prescribed medications. In all three records, each youth were given medications pursuant to current and valid orders, where applicable the medications were continued, discontinued, changed or a new one ordered, and the DHA/psychiatrist placed an order on the Practitioner Order form which was documented in the progress notes. One of the three applicable youth was in controlled observation and was given medications as prescribed. The program utilized the Department's Medication Administration Record (MAR) to document all medication and treatment provided. The MARs clearly indicated start and stop dates of the medications, the staff initialed each administered medication entry, and documented at a minimum weekly side effect monitoring on the form. None of the MARs had any lapses or errors and the six rights of medication delivery/administration were maintained.

One of the three youth refused medications which was clearly documented on the MAR and Refusal form. All medications were stored in securely locked areas inaccessible to youth. The medication cart is stored in the clinic, in a locked room. The remaining stock medications and sharps are stored in the medical clinic/exam room in locked cabinets. The different types of medications are kept separated in the locked cabinets. The non-controlled youth medications and some over-the- counter medications (OTC) were maintained in the locked medication cart. At the time of the annual compliance review, the program did not have any controlled medications or narcotics. The program does have a locked silver box in the locked medication cart to store the medications when needed; therefore, being securely stored behind two locks. The medication cart was clean and well organized with dividers for the different types of medications. All oral medications are stored separately from topical medications, as well as youth medications being kept divided. A separate small locked refrigerator located in the medical clinic office for medications which require refrigeration. A medication pass was observed for five youth. Each youth was brought separately to the medical clinic for medication pass. The medication cart was placed in the doorway of the medical clinic and the nurse would

request the youth's name, the medication each youth was taking, the side effects of the medication, and the dosage of the medication. The medication was verified and placed in a small container and handed to each youth with a cup of water. Each youth took the medication, coughed, and opened the mouth to show nothing remained. Two of five interviewed youth indicated they do not take medications. The remaining three youth stated the nurse provides the medication. One youth stated they are given medication by the nurse with the supervisor present. The nursing staff interview indicated the RN completes a prescription verification form to verify a youth's medication regimen when a youth is admitted with medications.

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

The program has a policy and procedures addressing medication/sharps inventory and storage processes. Unused medications shall be returned to the pharmacy on a monthly basis. Medications shall be packed in a designated container with the Return to Pharmacy form. Stock medications shall be checked monthly to ensure return of drugs which have expired. Controlled substances shall be destroyed by the health services administrator (HSA)\designee and consultant pharmacist on a monthly basis. Needles, syringes, and other disposable medical equipment and supplies shall be properly disposed of at least once a month. All medications were stored in securely locked areas inaccessible to youth. The medication cart is stored in the clinic in a locked room and the remaining stock medications and sharps are stored in the medical clinic/exam room in locked cabinets. The different types of medications are kept separated in the locked cabinets. The non-controlled youth medications and some of the over-the-counter medications (OTC) were maintained in the locked medication cart. At the time of the annual compliance review, the program did not have any controlled medications or narcotics. The program does have a locked silver box in the locked medication cart to keep the medications when needed; therefore, being securely stored behind two locks. The medication cart was clean and well organized with dividers for the different types of medications. All oral medications are stored separately from topical medications, as well as youth medications being kept divided. A separate small locked refrigerator is located in the medical clinic office for medications which require refrigeration.

A review of the last six months of sharps and OTC medication inventory confirmed the sharps and OTC medications were counted on a weekly, as well as perpetual basis. An inventory of two youth medications, three OTC medications, and three sharps all had documentation of the correct inventory amounts.. Only one youth was prescribed controlled medications during the annual compliance review period but the medication was discontinued prior to the annual compliance review The controlled medication had a shift-to-shift inventory count documented on the youth's Individualized controlled medication inventory record. The program provided training to non-healthcare staff assisting with self-administration of medication when nursing staff are not on-site. The nursing staff interview indicated the process for secure storage and routine inventory of medications is to complete a weekly inventory of all stock medications. The disposal of medication process is for two registered nurses (RN) or the pharmacist consultant to dispose of medications. The program's practice in securing controlled substances such as controlled medications is to store them behind two locks, and document and complete a count with two staff every shift.

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

The program has infection control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, in accordance to the Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control (CDC) guidelines. The infection control procedures included common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infection diseases, tuberculosis (TB), hepatitis A, B and C and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan also encompassed other outbreaks of epidemics caused by any other infectious agent (COVID-19), outbreak of pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms, food-borne illnesses, and bio-terrorist agents. The infection control procedures discussed chemical exposures in the workplace, hepatitis B immunizations, personal protective equipment (PPE), and standard universal precautions which need to be followed by all staff. The program has a comprehensive process for needle stick post-exposure evaluation contained in the infection/exposure control procedures. The exposure control plan was written in accordance with the OSHA standards and was reviewed and signed by the program administration. The plan included risk assessment and methods of compliance. The program did not have any instances which the local county health department, CDC, or the Central Communications Center (CCC) had to be contacted due to infectious diseases, quarantining, or hospitalization of staff or youth. The facility administrator interview indicated the exposure control plan is in the clinic and is reviewed yearly with staff.

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's policy and procedures indicate 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 behavior management system. The program's staff to youth ratio is 1:8 for daytime activities and 1:10 for sleeping hours. An observation of staff and youth interactions during the annual compliance review period, validated the program adheres to their policy. The daily schedule is posted on the dormitory for youth to view which documents a full schedule of activities. Through observation it was determined staff monitor youth behavior and consistently apply the program's behavior management system. During the annual compliance review, observations of video verified there were no youth unaccounted for at any time. Three staff were randomly selected and interviewed; each were able to explain the procedures when they are unable to reconcile youth count to stop all movement and recount.

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 relating to the program's behavior management system (BMS). The BMS is clearly written and located in the Youth and Parent Program Handbook. The incentives, positive and negative consequences, rules governing conduct and all required elements of the BMS are included. The program maintains an agreement with the school board which addresses the safety and security of youth while in the classroom. Five youth case management records were reviewed and each documented the youth signed an acknowledgment receipt of the Youth and Parent Program Handbook on the day of admission. The BMS has not changed since the last annual compliance review. The BMS contains all the required elements which includes addressing a minimum of a 4:1 ratio of positive to negative consequences. The program maintains an incentive calendar for each month which includes nightly privileges, Super Monday, Phat Friday, and Gotchas. Each youth are able to earn points and purchase items from the program's point store. A review of the BMS validates it meets the program's contractual requirements. Five youth were interviewed and each indicated they can lose their privileges and free-time as a consequence to negative behavior. Five staff were interviewed and each were able to explain the program's BMS. The five staff indicated canteen and Gotchas are incentives each youth is able to earn through the BMS. The staff further indicated youth are able to explain their behavior in person and also indicated items cannot be

taken away from youth as a consequence to negative behavior. The program's facility administrator (FA) indicated the program utilizes a token economy/point system where youth earn points based on their behavior. The FA further stated the program has several ways of ensuring rewards outnumber the consequences and indicated they utilize Gotcha's, food from McDonald's, Mega Monday, and Phat Friday along with daily incentives. The FA indicated consequences are monitored through treatment teams and are also reviewed in the morning meetings.

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 relating to the program's behavior management system (BMS), which addresses staff receiving feedback regarding the implementation of the program's BMS. A review of position descriptions validated staff whose job functions include implementation of the program's BMS are evaluated on an annual basis during staff evaluations. The program's policy and Youth and Parent Handbook indicates youth are given the opportunity to explain his or her behavior. The program's BMS does not include increased length of stay, denial of youth's basic rights or services, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement. A review of five staff in-service and five pre-service training records validate each received training on the program's BMS, which addresses the implantation of the BMS in the classroom. Education staff were trained by the facility administrator (FA) on October 14, 2019 on the jointly combined BMS plan to include the use during school hours. The program's assistant FA indicated the program does not utilize room restriction. Five youth were interviewed and were able to indicate what level in the BMS they were on and able to explain the BMS. Each youth also felt the staff are fair in handling negative behavior. When the five youth were questioned on the incentives they are able to earn, each indicated canteen, a later bedtime, McDonald's, Wendy's, noodles, video games, and cake. When questioned if youth are permitted to punish other youth, each of the five youth indicated no. Each youth also indicated staff are fair and consistent with incentives. All five youth feel the BMS is fair. Five staff were interviewed and indicated administration has an open door policy and supervisors provide feedback to staff regarding the implementation of the BMS. The FA was interviewed and indicated the points system, along with the Problem Behavior Reports are reviewed each shift by the shift manager to determine if any other action is needed. The FA further indicated each youth who made their points for the day are discussed during the morning meeting.

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's policy and procedures indicate the program shall ensure staff observe youth at least every ten minutes while they are in their rooms, either during sleep, rest periods, or other times. The policy further states staff observations shall be completed and documented in real time ensuring the safety and security of each youth. The program maintains 108 cameras and all were operational during the annual compliance review. The cameras maintain video footage for a total of thirty days. An observation of six dates, on all three shifts, and both dormitories validated all checks were completed within ten-minutes. The video footage was compared to the ten-minute check sheets and all were in compliance and matched the video footage. Five staff were interviewed and indicated room checks are conducted every nine minutes when a youth is placed in their room for sleeping or non-punishment reasons.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

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

The program's policy and procedures indicate formal counts take place at least three times daily and following each outdoor activity. Informal counts shall take place consistently throughout the program. A review of the program's logbooks validated counts are conducted at the beginning of each shift, after each outdoor activity, and during any emergency situation. All youth movement is captured in the logbook along with when youth are away from the program. Counts were observed several times during the annual compliance review and were completed, as required. Five staff were interviewed and each indicated youth counts are conducted hourly and after each code.

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

The program's policy and procedures include logbook entries and shift report review. The program maintains one logbook at any given time, which is maintained by master control and is bound with numbered pages. A review of each logbook was found to be pre-printed with sections such as shift report, youth movement and counts, statistical information, shift summary notes, and documented all required events. A review of the program's logbooks validated all entries are made in ink with no erasures or white-outs;. None were obliterated or removed. If errors were noted, there was a single line struck through, initialed, and dated by the person correcting the error. Each entry includes the date and time of the event, the name of the staff and youth involved in the event, a brief description, and the signature of the staff making the entry. The program conducts shift briefings for each shift change and documents the information on a shift report, which each incoming staff reviews and signs. Each shift report is maintained for a minimum of forty-eight hours for the staff to review, if needed. The logbooks for the last six months were reviewed and validated all Central Communications Center (CCC) and/or Florida Abuse Hotline reports were captured in the logbooks.

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

The program has a policy and procedures regarding key control and inventory of program keys. The policy addresses key assignment and usage, inventory and tracking of keys, secure storage of keys, procedures addressing missing or lost keys, and reporting and replacement of damaged keys. The key control inventory is captured daily on each shift and documented on the Daily Key Control Inventory Log. A review of all key control inventories for the last six months, validated the program is adhering to their policy. Through observation, it was validated staff turn in personal keys and in exchange obtain program keys. Staff sign in and sign out the program keys on the Key Control Log. Three staff's key rings were observed and matched the program's key inventory log. The key storage boxes are maintained in master control which is locked at all times. When keys are not in use, they are stored in the locked key storage boxes. The master control operator indicated restricted keys are stored in a separate key storage box, which was also confirmed through observations.. If keys are lost or missing, the program stops all movement to search for the missing keys. If the keys are not found, a call is made to the Central Communications Center (CCC). There were no incidents involving key control which should have been reported to the CCC, since the last annual compliance review. Five staff were interviewed and each was able to explain and confirm knowledge of the key control process.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program has a policy and procedures which documents the process to prevent contraband from entering the program. The program's policy as well as the Youth and Parent Program Handbook, includes a list of contraband and the consequences for being found with contraband. The policy addresses the consequences for staff if found with contraband. Searches conducted of the facility plant, facility grounds, and youth are captured in the program's logbooks. Weekly room searches are conducted and captured on a weekly room search form which contains the date, name of the dormitory searched, items confiscated, and disposition of the items. The program also completes a search of all incoming and outgoing mail which is captured on the Mail Correspondence Checklist. The program completes weekly room searches. Any searches resulting in confiscation of illegal contraband is documented and captured in each youth's case record. The program has not confiscated any illegal contraband in the last six months.
The facility administrator (FA) was interviewed and indicated any illegal contraband is turned over to the Sheriff's Department. Non-illegal contraband is secured in the FA's office and photographed until the investigation is complete and then disposed of off-site.

5.09 Searches and Full Body Visual Searches	Satisfactory Compliance

The program shall perform searches to ensure no contraband is being introduced into the facility.

The program has a policy and procedures regarding searches, which states searches of all youth shall be completed by a staff member of the same gender as each youth. In addition, the policy states staff shall avoid use of unnecessary force and shall treat youth with dignity and respect to minimize youth stress and embarrassment. A review of searches during the annual compliance review validated the staff adhere to the program's policy regarding searches. Staff explained the reason for the search and each search was conducted according to the Protective Action Response (PAR) training manual. There were no admissions, transportations, visitation, or youth work projects during the annual compliance review. Five youth were interviewed and each indicated searches are conducted for every movement. Five staff were interviewed and four indicated searches are conducted for every movement and after every code. One staff indicated after every movement.

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's policy and procedures address vehicles and maintenance. The program possesses two program vehicles which they maintain and utilize for the transportation of youth. Invoices of the program vehicles were reviewed and validated. One program's vehicle annual inspection was completed on December 10, 2019 and the remaining vehicle inspection was completed on December 11, 2019; no deficiencies were identified. A transport was not conducted during the annual compliance review week. A random search of personal and program vehicles conducted during the annual compliance review, found no vehicles unsecure. A search of each program vehicle was conducted and it was observed they were equipped with a safety screen separating the front seat from the back seat. In addition, each vehicle contained a fire extinguisher, a steering wheel lock, and appropriate number of seat belts. The doors to the youth area was unable to be opened from the inside. The first aid kit for each vehicle is maintained inside the program until a transport takes place, during this time the keys and first aid kit are obtained. Each key ring contains a seatbelt cutter and a window punch. An interview with the staff member who maintains the program vehicles and conducts all transports indicated both staff and youth must always wear a seatbelt. A Pre/Post Transportation Inspection Form is completed prior to and after each transport. Youth are secured by a seatbelt during transport, no other means are used to attach each youth to the vehicle.

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.	

A review of the program's policy and procedures validated it contained all the requirements of the Department's policy regarding transportation of youth. The program's policy indicates transporting staff shall have a cellular phone for use in the case of an emergency during the transport. The program staff member who conducts all transports stated the program's policy indicates a 1:5 staff-to-youth ratio of the same gender; however, the staff specified they never conduct a transport without at least two staff. The staff further stated youth are permitted to drive program or staff vehicles which is in adherence to the program's policy. According to the staff, youth and staff always wear their seatbelts and are never attached to the vehicle. A search of each program vehicle was conducted, and was observed they were equipped with a safety screen separating the front seat from the back seat. A transport was not conducted during the annual compliance review week. A random search of personal and program vehicles conducted during the annual compliance review, found no vehicles unsecured. The program conducts monthly driver's license checks of all staff who operate a program vehicle to validate each have a current license. A review of the reports validated all staff have a valid driver's license. Five staff were interviewed and each indicated a cell phone is provided to staff during transports. They further stated no staff are permitted to use their personal vehicle 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's policy and procedures address who is responsible for conducting the weekly safety and security audits, which includes corrective actions and a process for an internal system to verify any deficiencies found are corrected. The policy meets all requirements of the Department's Rule. A review of weekly safety and security audit documents over the last six months, validated all inspections were completed every seven days with the exception of three times. One inspection was one day late, one inspection was three days late, and one inspection was not completed. The week the inspection was not completed, the assistant facility administrator (FA) who completes the weekly audits, was on leave. The FA was interviewed and indicated the program completes a report based on the information from each morning meeting report. This information is totaled each month and compared to the previous month. A meeting of the management team is conducted to plan how to reduce the deficiencies. There are also internal reviews completed by corporate staff to verify deficiencies are being reduced.

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

The program's policy and procedures address issuance, inventory, and control of the program's equipment and tools. An observation of the two outside sheds validated all tools are maintained on a shadow board. Each building is secured and inaccessible to youth. Class A tools are inventoried daily and as they are used. Class B tools are inventoried monthly. A review of each of the inventories both Class A and Class B validated each were completed, as required. All tools are inventoried after each use. The program's assistant facility administrator (AFA) indicated no youth are permitted to use any class A tools. The program does not have any machetes, bowie knives, or any other long blade knives on the premises. The program's procedures are followed if any tools are lost or missing. The program has not had any lost or missing tools since the last annual compliance review. The maintenance staff indicated any tools which are dysfunctional are disposed of and replaced, as needed. All staff are trained during pre-service training on the intended and safe use of tools. Youth are not trained on the intended and safe use of tools, as they are not permitted to utilize any tools. A review of five staff's pre-service training records validated all were trained on the intended and safe use of tools. Five staff were interviewed and two indicated the only tools youth are permitted to use are mops and brooms.; All five indicated it depends on each youth's alerts and safety plans.

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's policy and procedures address youth supervision when using tools. The policy states youth are allowed to use mops, brooms, dust mops, push brooms, dust pans, and mop buckets under the direct supervision of staff. A risk assessment will be conducted on each youth prior to the handling of tools. Youth are only permitted to use Class B tools and no Class A tools. A review of five youth records validated each youth received an updated risk assessment and are utilized prior to each youth using Class B tools. One youth was observed utilizing a mop during the annual compliance review week, the youth was supervised by a staff

member. The staff-to-youth ratio when youth are utilizing Class B tools is 1:5. Youth are searched prior to and after each use of Class B tools. Five youth were interviewed and each indicated the only tools they are permitted to use are mops and brooms.

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

A review of the program's policy and procedures validated the program established guidelines for outside contractors including tool control and restrictions. Three invoices were reviewed and compared to the contractor sign-in/instruction sheets. Each of the contractor sign-in/instruction sheets were completed in their entirety. Each contractor sign-in/instruction sheet included a tool check in and check out process, tool restrictions, youth restrictions while contractors are on sight, and missing tool follow-up. There were no missing tools identified of the three reviewed. A review of the program's policy indicated the facility administrator (FA) is responsible for allowing personal cell phones and/or electronic devices, capable of taking pictures on-site if such items are required.

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's policy and procedures include fire, safety, and evacuation drills. A review of the program's drill schedule validated the program has a system in place to perform drills each month; specifically for fire drills and additional emergency drills. A review of the fire drill documentation validated a fire drill was conducted each month on each shift. Each reviewed drill documented the date and time of the drill, type of drill, participants, brief scenario, findings, and recommendations. In addition to the fire drills, additional drills were reviewed which included escape, disturbance/riot, hostage, and weather drills. Fire evacuation routes and egress plans were observed throughout the program. A review of the program's fire extinguishers confirmed each was inspected in January 2020 including the two for the program vehicles. Five youth were interviewed and each indicated they have been instructed on what to do in case of a fire. Three of the youth indicated fire drills are conducted twice a month, two indicated once a month, and one indicated once or twice a month. Five staff were interviewed and each indicated they have participated in weather, major disturbance, bomb threat, hostage situation, chemical spills, flooding, escape, and fire drills. The facility administrator (FA) was interviewed and indicated they utilize a drill schedule which is guidance for the program to perform specific drills; however, the FA indicated this is a guidance and they are not required to perform each drill on the schedule as long as they conduct the drills required by the rule and standards.

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's policy and procedures include disaster and continuity of operations planning. The Continuity of Operations Planning (COOP) is accessible to staff and posted in the facility administrator's (FA) office, master control, and the conference room which is utilized for staff briefings. The program submitted their COOP to the Department for approval on March 13, 2020 which was approved on March 18, 2020. The approved plan addresses alternative housing plans. The program's disaster plan is combined with their COOP. The program maintains equipment and supplies for the continuous operation and services during emergency situations. The program's disaster plan is part of the program's COOP. The plan addresses alternative housing measures which was approved by the Department's regional director. The program's COOP annexes were updated prior to being submitted to the Department for approval. In addition, the COOP includes all required provision for the new COOP requirements. The program maintains an administrative hardcopy file containing critical identifying information for each youth in the event of an emergency. The hardcopy file is maintained in master control. The FA was interviewed and indicated a copy of the COOP plan is located in master control, the assistant FA's office, and the FA's office for staff to review.

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

The program's policy and procedures address the storage and inventory of flammable, poisonous, and toxic items and materials. All such materials are secured and located in a locked shed on the program's property and inaccessible to youth. The program maintains a list of staff who are permitted to handle such items which includes both maintenance staff and the facility administrator (FA). A review of the program's flammable, poisonous, and toxic items and materials on hand confirmed it matched the program's inventory of such items. The inventory is completed monthly and when such items are utilized. The program maintains Safety Data Sheets for each item and is located with the flammable, poisonous, and toxic items and materials.

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

The program's policy and procedures address youth handling and supervision for flammable, poisonous, and toxic items and materials which states no youth are to handle such items. In addition, youth do not clean, handle, or dispose of any person's bio-hazardous material, bodily fluids, or human waste. The program's flammable, poisonous, and toxic items and materials are maintained in an outside shed which is locked at all times and inaccessible to youth and has limited staff access. One youth was observed utilizing a mop during the annual compliance review week, the chemicals were only utilized by the staff member and not the youth. A review of the program's Preventive Maintenance Checklists confirmed checks are completed each week and are conducted as outlined in the Department's Rule. Five youth were interviewed and each indicated they do not use any chemicals or cleaning products.

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

The program's policy and procedures address the disposal of flammable, toxic, caustic, and poisonous items which is in accordance with Occupational Safety and Health Administration (OSHA) standards. The program's policy has a process for any chemical spills which addresses the required elements. The facility administrator (FA) indicated they have not disposed of any such items with the exception of kitchen grease. Kitchen grease is disposed of through an outside company and is stored in a grease trap while on-site. Kitchen liquid waste such as dirty mop water or unused beverages is disposed of in plumbing drains. As a result, the program did not have any disposal logs since the last annual compliance review. The program maintains a Safety Data Sheet (SDS) for all chemicals and if needed, would be disposed of in accordance with the SDS. In the event the disposal of such items is required, the two maintenance staff are responsible for the safe and lawful disposal. The maintenance staff are trained upon hire on the program's policy regarding disposal of such items. The maintenance staff and the facility administrator indicated the only flammable, toxic, caustic, and poisonous items disposed of is kitchen grease. It was further indicated there were no disposals since the last annual compliance review due to utilizing all such items in their entirety.

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’s policy and procedures regarding visitation and communication indicated visitation sessions are offered on Saturday and Sunday from 1:00 p.m. to 4:00 p.m. The program’s policy regarding telephone contact with family members indicated an approved correspondence list is required to be completed on the day of each youth’s admission to the program. All youth will have the ability to make at least one telephone call each week. The program’s policy regarding written correspondence indicates staff shall encourage youth to write parent/guardians at least once a week. In addition, all mail, both incoming and outgoing shall be visually inspected. A review of the program’s visitation logs for the last six months validated visitation took place on Saturday and Sundays. The log documents the date, visitor name, youth name, verification visitor is on approved correspondence list, time in/time out, visitor rules are provided, identification is checked, a search of the visitor is completed, visitor signature, and a staff signature. In addition, there is a Youth Search Documentation form completed for each

youth validating a search after visitation. Through observation, it was determined the visitation schedule is posted on the dormitories. In addition, the schedule is located in the Youth and Parent Handbook. The handbook addresses alternative visitation arrangements if necessary. A review of the program's telephone call list validated youth are scheduled for one phone call a week, were able to contact their families each week, and if a youth was unable to reach a family member, it was documented where each youth was given another opportunity to reach out to their family. The mail correspondence checklist documents the mail is incoming or outgoing, the review of the mail, youth signature, and a staff signature. A review of the mail correspondence checklists validated youth are able to receive and send mail. Five youth were interviewed and each indicated they have been given the opportunity to communicate with family members by mail, telephone, and 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's policy and procedures indicate controlled observation may be used as an immediate short-term crisis management strategy when a youth's aggressive, violent or potentially dangerous behavior substantially threatens the physical safety of others, compromises program security, and when non-physical interventions would not be effective.

Each dormitory has two controlled observation rooms. Each controlled observation room was observed while the review team was on-site and meets all required elements. Five youth records were reviewed for youth who were placed in one of the program's controlled observation rooms. Each record documented the date-in, time-in, date-out, time-out, staff inspection of the controlled observation room, and validation the staff member who searched each youth was the same gender as the youth.

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

The program's policy and procedures address controlled observation. The program utilizes a Controlled Observation Report, a Controlled Observation Safety Checks form, a Controlled Observation Search and Placement Protocol form. A review of five youth's controlled observation documents validated none of the youth placed in a controlled observation room were exhibiting behaviors indicative of a mental health crisis or suicide. The assistant facility administrator (AFA) authorized the placement once and a supervisor authorized the placement four times for each of the five youth. Two youth demonstrated both active aggression toward others and violent behavior, while two only displaced active aggression toward others, and one only displayed violent behavior. Each of the five youth records validated staff needed to quickly gain control and order for the program's safety and security. The staff advised each of the five youth regarding the reason of placement in the controlled observation room. The program utilizes a Health Status Checklist to document the health status check conducted when a youth is in a controlled observation room. Each of the five records documented a health status check was completed resulting in no medical issues. The AFA or a supervisor granted an extension for each youth for a two-hour period beyond the initial two hours they were in controlled observation. None of the youth's placements exceeded twenty-four 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's policy and procedures indicate which staff can approve controlled observation. The program utilizes the Controlled Observation Report to document the placement of each youth in a controlled observation room. Five youth's controlled observation documents were reviewed. Each of the five reports were completed and submitted to the supervisor for review. Staff conducts and document safety checks on the Controlled Observation Safety Checks form. Each of the five Controlled Observation Safety Checks forms were completed and validated each check was conducted at a minimum of every fifteen minutes. The assistant facility administrator (AFA) and the program manager documented written approval for each of the five youth's release from controlled observation. The youth's Controlled Observation Report documented each was released based on behavior and it was determined they were no longer a threat to themselves or to others. The Health Status Checklist and Controlled Observation Safety Check forms are maintained in a binder in administration. These documents are not stored in the youth's individual management record; however, the AFA indicated the forms are placed and maintained with each youth's record after release. The AFA reviewed and approved the Controlled Observation Report on the day each of the five youth were released from controlled observation. The internal alert was updated for each of the five youth upon release from controlled observation. Five youth were interviewed and three indicated they have been sent to their room as a punishment and the door was shut and locked. It was clarified with the three youth they were referring to being placed on controlled observation, to have time to calm down and removed from the other youth, rather than as a punishment.

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's policy and procedures regarding safety plans indicate the initial planning process must begin with the multidisciplinary treatment team during their initial contact with each youth and shall be completed within fourteen days upon admission. A review of five youth's safety plans validated their safety plan was completed on their day of admission, with the exception of one youth record which was completed within the required fourteen days. Each reviewed safety plan included warning signs, youth baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies, and each youth's debriefing preferences. Parent/guardian contact is made during admission classification for each youth where information pertaining to safety plans is captured. In addition, parent/guardian contact is maintained during treatment team and family sessions. Safety plans are updated monthly; however, mental health staff indicated they will complete the updates during treatment team meetings moving forward. Each of the five reviewed safety plans validated each plan was jointly prepared by each youth, parent/guardian, and program's clinical staff. Each safety plan incorporated the clinical assessment recommendations and were updated every thirty days. Safety plans are stored in the program's conference room where daily briefings occur, where they are accessible to staff at any time. Safety plans are also reviewed with staff during the monthly all staff meeting. Five youth were interviewed and four indicated they were involved in the development of their safety plan, one youth indicated they could not remember. Five staff

were interviewed and indicated youth safety plans are located in the briefing room/conference room and are reviewed in the all staff meetings.