STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Lake Academy

TrueCore Behavioral Solutions, LLC
(Contract Provider)
9540 East Columbus Drive
Tampa, Florida 33619

Review Date(s): September 17-20, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; or limited, unintentional, and/or non-systemic exceptions 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:

Canitha Taylor, Office of Program Accountability, Lead Reviewer (Standard One)
Jamila Bacchus, Office of Program Accountability, Regional Monitor (Youth/Staff Interviews)
Danielle Letchner, Youth Environmental Services, Compliance Specialist (Standard Two)
Stephanie Lobzun, Office of Program Accountability, Regional Monitor (Standard Four)
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor (Standard Five)
Amanda Nelson, Office of Program Accountability, Regional Monitor (Standard One)
Rowena Rose, Office of Education, Education Coordinator (Standard Two)
Paul Sheffer, Office of Program Accountability, Regional Monitor (Standard Three)
Jonathan Thompson, Office of Program Accountability, Regional Monitor (Standard Three)

Program Name: Lake Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Hillsborough County / Circuit 13
Review Date(s): September 17-20, 2019

MQI Program Code: 1069
Contract Number: R2104
Number of Beds: 50
Lead Reviewer Code: 146

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
1.14 Internal Alerts System and Alerts (JJIS)*	1.10 Delinquency Intervention and Facilitator Training
1.17 Advisory Board	2.17 Educational Access
3.13 Suicide Prevention Training *	5.04 Ten Minute Checks *
5.15 Outside Contractors	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Provision of an Abuse-Free Environment *	Satisfactory
1.04	Management Response to Allegations *	Satisfactory
1.05	Incident Reporting (CCC) *	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	Pre-Service/Certification Requirements *	Satisfactory
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Failed
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)*	Limited
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Limited
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/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	Satisfactory

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Failed
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Limited
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

Lake Academy is a fifty-bed program, for twelve to nineteen-year-old females, located in Tampa, Florida. The program is operated by TrueCore Behavioral Solutions, LLC., through a contract with the Department. The program provides the following services: intensive mental health treatment and borderline developmental treatment, and intensive medical overlay services. In addition, the program fosters each youth by providing several curricula to support delinquency interventions, life skills, and gender-specific training. Treatment curricula include: Teen Relationships, Girls in Real Life Situations, Conflict Resolution from the Inside Out/Helping Teens Manage Conflict in the Real World, Living in Balance, and Thinking, Feeling and Behaving. Additional treatment services are provided through Dialectical Behavior Therapy, therapeutic art groups, weekly individual sessions and monthly family therapy. Delinquency interventions are given through the Impact of Crime and Thinking for a Change curricula. Gender-specific treatment is provided through the Voices and SAVVY Sisters curricula. Program administration is comprised of a facility administrator and one assistant facility administrator. Case management services are provided by one director of case management, three case managers, and one transitional services manager. Mental health staff at the program includes one director of clinical services, one assistant clinical director, one recreational therapist, one certified behavior analyst, five therapists, and one contracted board-certified psychiatrist. Medical services are offered daily and are provided by one registered nurse health services administrator, five registered nurses, one licensed practical nurse, and one contracted board-certified medical doctor. Educational services are provided by the Hillsborough County School District. The layout of the program includes one main building which has an area for administration offices, case management and mental health offices, a cafeteria, a kitchen not currently used, a medical clinic, three living units, a centralized master control room, and educational classes. The program contracts with Lintons Food Services to provide all meals. Meals are prepared across the street at Tampa Residential Facility and brought over to Lake Academy. At the time of this review forty-five of the program's forty-six security cameras were operating. One camera was knocked down by a youth and a new camera needs to be reinstalled. At the time of the annual compliance review, the program reported twelve youth care worker position vacancies, one case manager vacancy, and one full time certified behavior analyst (CBA) vacancy. The program's most recent contract amendment went into effect August 1, 2019 and included the requirement for the program to employ a full time CBA. The program has no waivers granted by the Department.

Strengths and Innovative Approaches

- The nursing department has implemented the “Lake Awareness Wall” located outside of the medical clinic. Each month represents a different health awareness topic and educational information for the monthly topic gets posted to the wall. The youth participate each month in decorating the wall and learning about the topic.

- The program offers a grief and loss group, provided by Suncoast Kids, on Wednesday evenings. This is ten-week closed group which allows members to learn how to grieve their loved ones who have passed away in a healthy manner, as well as teaches them various ways to honor the memory of people in their live who have passed away..

- More Too Life has partnered with Lake Academy to offer additional mentoring services for commercial sexual exploitation of children (CSEC) victims by human trafficking survivors. More Too Life is working with victims of human trafficking once a week on exploring education, career skills, goal setting, gender studies, mutual respect, and various forms of sexual violence prevention.

- Mentors from Steadfast Mentoring come in to assist girls within the first month of admission to help the girls settle in. Mentors are there to provide spiritual, emotional, and physical support in addition to assisting with activities at the program such as family day and spring break activities. The mentors do activities with girls during visitation on the weekends.

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 for the background screening of all employees, volunteers, contracted providers, and interns prior to employment. The program's procedures are to complete a new background screening on every new hire without exception. The program has hired twenty-eight program staff (twenty-two direct care staff) and sixteen mentors/volunteers since the last annual compliance review. There have not been any new contracted staff or interns hired since the last annual compliance review. A review of personnel records indicated all new staff and mentors/volunteers had a final background screening completed prior to their date of hire and none of the staff or mentors/volunteers had a criminal history. Background screenings are completed through a Live Scan background check, which is verified through the Agency for Healthcare Administration (AHCA) Clearinghouse. Each of the twenty-two applicable records for direct care staff contained a pre-employment assessment with a passing score. As of September 2019, the provider is utilizing the Berke Assessment for pre-employment assessment of direct care staff. Prior to September, the provider was utilizing the Ergometrics IMPACT for Juvenile Corrections exam. Each of the reviewed records also revealed the hiring authority reviewed the Central Communications Center (CCC), Staff Verification System (SVS), and the Florida Department of Law Enforcement (FDLE), Automatic Training Management System (ATMS) as part of the pre-employment background screening process. The program's AHCA Clearinghouse employment roster included all staff and volunteers. None of the records in the reviewed sample required an exemption by the Department. The program and the Hillsborough County School Board both submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit (BSU) on January 23, 2019, meeting the annual requirement.

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

The program had three staff who were eligible and met the requirements for a five-year background rescreening. Each of the records contained evidence the staff received an eligible rescreening completed at least ten days prior to their five-year anniversary date or retained prints expiration date, with the information submitted to the Department's Background Screening

Unit/Clearinghouse. The program had no volunteers, mentors, interns, or contracted staff who were applicable for a five-year rescreening.

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

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

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

The program has a policy and procedures which promote an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. The policy states there is zero-tolerance regarding any abuse. The program's procedures indicate all staff are to immediately report any knowledge or suspicion regarding an incident of abuse or harassment which has occurred in the program. The procedures further state a youth's refusal to make a call themselves does not relieve the staff from being mandated to call the Florida Abuse Hotline if the staff has reasonable suspicion abuse has occurred. Upon hire, all staff receive a new employee handbook and sign an acknowledgement form. This form is signed by all staff and indicates they received and understand all the items included in the employee handbook to include the code of ethics and abuse reporting procedures. A review of seven personnel records, for staff hired since the program's last annual compliance review, revealed each contained a copy of the signed acknowledgement form.

A tour of the program verified the Florida Abuse Hotline and the Central Communications Center (CCC) phone numbers were posted throughout the program. There is a telephone in the main hallway of the program outside of the cafeteria. This phone allows each youth to have direct access to the Florida Abuse Hotline. If youth are in another area of the program and wish to make an abuse call, staff will call for a supervisor or another staff person to escort the youth to make the phone call either on the abuse call phone or on an office phone if the youth is over eighteen and a call to the CCC needs to be made. According to program, policy, staff are to maintain sight and sound supervision of the youth while maintaining distance far enough to not overhear the details or subject of the youth's call. All allegations of abuse or neglect, as well as CCC reports are logged and maintained in the program's logbook. Upon admission and during

the orientation process, all youth are informed of their rights to report abuse to the Florida Abuse Hotline or the CCC, if they are over eighteen years of age. A review of seven youth case management records revealed each contained an orientation checklist signed by the youth, acknowledging their receipt of this information. A review of seven pre-service staff training records indicated all of the staff were trained on the abuse reporting requirements prior to contact with youth. A review of documentation revealed the program completed a yearly TRACE self-assessment. A review of all incidents since the last annual compliance review found one substantiated incident involving excessive use of force. The staff person involved was terminated and ineligible for rehire.

Seven youth were interviewed, and each youth indicated they feel safe at the program. Six of the seven youth stated they have never been stopped from reporting abuse to the Florida Abuse Hotline or CCC since they have been at the program. One youth stated she was denied a call three months ago when there was no air conditioning and it was very hot in her room. The youth stated she asked staff to make a call and staff ignored her request. During the interview, the annual compliance review team member offered the youth an abuse call; however, she denied the call since the problem was resolved a while ago. Seven youth were asked if staff are respectful when talking to them and other youth. Six youth said yes, and one youth said depending on the staff, they may use a disrespectful tone or curse at youth. When seven youth were asked if they have heard staff use curse words when speaking to them or other youth three said never and four said once or occasionally. When the four youth were asked to explain further, one youth said staff jokingly cursed to a youth in a funny conversation, and another youth said most of the staff who cursed are no longer here. Two youth said floor staff will use curse words when youth are not listening.

Seven staff were interviewed and asked to explain the process for allowing staff and youth to call the Florida Abuse Hotline or CCC to report suspected abuse. Three staff said they would notify their supervisor, six said they would allow the youth to make the call, and one said staff can call. Only one of the seven staff stated they have observed a co-worker tell a youth they could not call the Florida Abuse Hotline; however, they added this staff no longer works at the program. One of the seven staff have observed a co-worker using profanity while in the presence of youth or use threats or intimidation; however, they state this was not directed at the youth and the staff no longer works at the program.

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

The program has a policy and procedures for incident reporting requirements. A review of the Department's Juvenile Justice Information System (JJIS) found the program had twelve incidents reported to the Central Communications Center (CCC) during the annual compliance review period for use of force/excessive or unnecessary. Eight of the twelve have been closed in the following manner: five allegations were unsubstantiated, one was inconclusive, one was unfounded, and one was substantiated. The staff member involved with the substantiated allegation was terminated and classified as ineligible for rehire. The staff's personnel record was reviewed, and documentation verified management's action to address the incident. In the last six months: four reports were made for improper conduct, two for medical neglect and two for depriving of food and water. Currently all reports are still open and under investigation except

for one incident of medical neglect which was closed and unsubstantiated. The program has one open incident for failure to report incident for failing to report to the CCC the arrival of a child protective investigator to investigate an abuse allegation.

An interview with the facility administrator (FA) revealed the program reviews program policies and procedures during general staff meetings and each staff is trained on the abuse reporting process when they are hired. Additionally, all CCC or abuse incidents are reviewed and reported in the morning management meetings and information is put into a database for tracking. The FA states youth receive information on how to contact the Florida Abuse Hotline and CCC upon arrival and receive reminders often.

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 for incident reporting requirements. A review of the Department's Juvenile Justice Information System (JJIS) found the program had sixty-four incidents reported to the Central Communications Center (CCC) during the annual compliance review period. Thirty-three reports were closed and thirty-one are open and still under investigation. This is an increase from the previous annual compliance review period. All incidents were reported within two hours of the incident or within two hours of becoming aware of the incident with one exception. Currently, the program has one failure to report incident from May of 2019, which is still open and under investigation. The incident report indicates the program failed to report the arrival of a child protective investigator to investigate an abuse allegation accepted by the Florida Abuse Hotline. A review of internal incident reports and grievances revealed none of the incidents reviewed met the eligibility requirements to be reported to the CCC. A review of six CCC reports found each of the incidents were reported within two hours and each were documented in the logbook as required. An interview with the facility administrator confirmed the program's practice in reporting incidents to the CCC.

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

The program's Protective Action Response (PAR) Plan was updated and approved by the Office of Staff Development and Training on December 21, 2018. The program reported a total of thirty-one PAR incidents since their last annual compliance review in March 2019. This is an increase from the seventeen incidents reported during the program's last annual compliance review. The program's rate during the annual compliance review period was 2.04, which is above the statewide residential PAR rate of 1.59. Over the last few months, the program has experienced a high amount of turn over and staff vacancies in each department. In July 2019, the Department responded by increasing the frequency of monitoring visits and the presence of Department staff. In August 2019, the program's contract with the Department was amended to increase the facility staffing requirement.

Eight PAR incident reports were reviewed. Each of the reports were completed by the end of the staff member's workday and included statements from all staff involved. None of the incidents resulted in injury to youth or staff and none involved the use of mechanical restraints. None of the reports indicated allegations of abuse or requests by the youth to call and report abuse. All reports were reviewed by a PAR certified instructor and the supervisor on-duty. A post-PAR interview was conducted with the youth by the administrator, or designee, within thirty minutes of the incident. None of the reports indicated a PAR medical review was necessary or required. Each of the reports were reviewed by the administrator, or designee, within seventy-two hours of the incident. The reviewer confirmed monthly summaries of PAR incidents are submitted to the Department by the fifteenth of each month.

The facility administrator (FA) was interviewed and asked to explain the process for monitoring PAR incidents and use of force. The FA stated reports are reviewed in each daily morning management meeting and reported for tracking in the morning meeting database. The assistant facility administrator (AFA) of operations conducts a video review of the PAR incident to ensure proper PAR procedures were followed, there was no use of excessive force, and to ensure PAR was a necessary level of response. Additionally, the FA states video reviews of incidents may also be reviewed by a master PAR instructor to ensure compliance with interventions as needed.

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 maintains a written pre-service training plan which outlines all staff training required by Florida Administrative Code, within 180 days of hiring. The program's training plan was submitted, in writing, to the Department and approved by the Office of Staff Development and Training on January 8, 2018. The plan was updated and approved again by the Department on April 13, 2019. The pre-service training plan includes course names, descriptions, objectives and training hours for all instructor-led trainings. Additionally, the plan indicates all staff must complete a minimum of 120 hours in the required topics. Seven pre-service training records (six youth care workers and two registered nurses) and the Department's Learning Management System (SkillPro) were reviewed for completion of pre-service training. Records indicated all seven staff completed over 120 hours of training. Each of the staff received training in the essential skills prior to any contact with youth with exception of the nurses who do not require Protective Action Response (PAR) training/certification. The program counts all youth care workers, transport staff, and shift supervisors in the primary staff-to-youth ratio. The program's assistant facility administrator, case managers, therapists, and recreational therapist have all applicable training and certifications to supervise youth when in their custody and can assist in ratio if needed; however, these staff being counted in ratio is not the program's prevailing practice.

A review of documentation revealed all instructors are qualified to deliver training provided. Training for all staff was documented in SkillPro, as required.

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 maintains a written in-service training plan which outlines all training required by Florida Administrative Code, each calendar year, effective the year after pre-service training is completed. The program's training plan was submitted, in writing, to the Department and approved by the Office of Staff Development and Training on December 18, 2017. The plan was updated and approved again by the Department on April 13, 2019. The in-service training plan includes course names, descriptions, objectives and training hours for all instructor-led trainings. Seven training records and the Department's Learning Management System (SkillPro) were reviewed for completion of in-service training. Each staff person completed more than the required twenty-four hours in the required topics: protective action response, cardiopulmonary resuscitation (CPR), automatic external defibrillator (AED), suicide prevention/intervention, and professionalism and ethics. None of the staff completed active shooter training in 2018; however, it was not a mandatory requirement in 2018. The program has added this SkillPro training to their 2019 in-service training plan and calendar. The total amount of training hours completed range from twenty-six hours to seventy-one.

One of the seven records was applicable for supervisory training. The facility administrator's (FA) training record was the only supervisory staff record applicable during this annual compliance review. All the remaining supervisors were hired/promoted in 2019 or reviewed as part of the sample during the last annual compliance review in March 2019. The FA completed eight hours of supervisory training in the topics of management, leadership, personal accountability, employee relations and communication skills. All staff received additional training in prenatal and neonatal education, monitoring, observation and emergency care of pregnant females, and the positive performance/behavior management system. One of the seven staff's regular assigned job duties included implementation of an evidenced based curriculum, life skills, and/or social skills and their training record indicated they received enhancement training.

The program counts all youth care workers, transport staff, and shift supervisors in the primary staff-to-youth ratio. The program's assistant facility administrator, case managers, therapists and recreational therapist have all applicable training and certifications to supervise youth when in their custody and can assist in ratio if needed; however, these staff being counted in ratio is not the program's prevailing practice.

Further review verified the training records for seven of seven nurses contained documentation of their current certification in CPR with 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 in place to describe the grievance process for youth. The process includes three phases (informal, formal, and appeal). The program encourages all youth to resolve their issue(s) informally. In the informal phase, youth can discuss her issues with the staff or supervisor on-duty or they can discuss them in the daily community meetings. The youth can submit a Chatty Cathy form, asking for specific staff to speak with; and the form prompts the youth to suggest a possible resolution. The program's procedures indicate informal complaints and Chatty Cathy forms are handled as expeditiously as possible. A Chatty Cathy form can be given to a supervisor or placed in the locked grievance drop box located in the cafeteria. In the formal phase, the youth can submit a written grievance to the supervisor or place the form in a grievance drop box. The locked grievance drop box along with blank Chatty Cathy and grievance forms are in the cafeteria and available to all youth. Additionally, staff keep blank forms on the unit for youth who request a form outside of the scheduled cafeteria time. The box is checked daily by the grievance officer/assistant facility administrator. The grievance officer will investigate the grievance and render a decision, in writing, to the youth within seventy-two hours of receiving the grievance (excluding weekends and holidays). Should the decision be in support of the grievance, actions to rectify the situation are made and the youth's signature is obtained to document their agreement. If the resolution offered does not support the grievance or the youth does not agree, the grievance is forwarded to the facility administrator (FA). The youth can appeal findings with the FA and the decision made will be final.

During a tour of the program, blank Chatty Cathy and grievance forms were found in the cafeteria and available to youth. In the last six months, the program has received nineteen grievances and thirty-nine Chatty Cathy forms. A sample of five grievance forms were reviewed; two of the complaints were for food, one for personal hygiene items, one for clothing, and one was to request a change in living units. All forms were answered within forty-eight hours and the youth agreed to the resolution. None of the grievances were taken to the appeal phase. All forms are logged and maintained in a binder for one year. A review of seven staff training records validated each of the staff were provided training in the program's grievance procedures during pre-service training.

Seven youth were interviewed, and all were aware forms are available in the cafeteria and they wait for a response after placing the completed form in the drop box. None of the youth indicated there were phases to the grievance system but two of the seven youth mentioned there are timeframes associated with each phase. All seven of the youth indicated they can ask for assistance in completing a grievance form. Seven staff were interviewed, and all seven were familiar with parts of the grievance process. Five staff mentioned blank forms are in the cafeteria. None of the staff mentioned the process has three phases but three stated each phase has associated timeframes. Two of the staff indicated a supervisor reviews the grievance and two stated the FA does.

In an interview, the FA was asked to explain the program's grievance process. She indicated all girls are treated fairly and given the opportunity to file a grievance at any time. The FA described the program's three phases as listed in the program's operating policy.

1.10 Interventions and Facilitator Training	Failed 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 provides delinquency interventions through evidence-based practice, promising practice, or a practice with demonstrated effectiveness for each youth. Evidenced-based interventions are those designed to reduce the influence of risk factors related to re-offending behavior. The program utilizes Thinking for a Change (T4C) and Impact of Crime (IOC) as the delinquency intervention models with each youth placed in groups according to their identified individual needs. Interviews with the program's clinical director and facility administrator (FA) confirmed delinquency interventions are delivered by the recreational therapist, the assistant facility administrator, the director of case management, and the restorative justice counselor. Master's-level licensed and non-licensed therapists provide therapeutic services to include individual counseling and group therapy. In an interview, the FA advised each youth is matched with their therapists based on each youth's individualized therapeutic needs. A review of each of the four designated staff's training records reflected all staff had the appropriate education and qualifications to be hired in their respective positions and completed the required training to facilitate the delinquency intervention groups. The program's daily schedule reflects delinquency intervention groups are conducted seven days a week, pursuant to the program's contract and a review of group sign-in sheets confirmed this practice. A review of seven youth individual performance plans supported each youth had at least one delinquency intervention goal addressing an identified priority need. A review of group sign-in sheets validated each youth was participating in an intervention group. Structured, planned programming, and activities are provided for a minimum of sixty percent of the youth's awake hours only during the weekdays, Monday through Friday.

Interviews were conducted with seven youth. All seven youth indicated they are participating in groups to include IOC, T4C, anger management, and VOICES. Each of the youth were asked if they are placed in their room for punishment reasons. Four youth said yes, and three youth said no. Of the four youth who said yes, they indicated on most weekends all youth in facility will get locked in their rooms (locked down) if other youth get into a fight. The review team members reviewed collateral information such as logbooks and visual check sheets to verify what was being reported by youth. The review team reviewed youth visual check sheets for every weekend in July 2019, one weekend in August 2019, and one weekend in September 2019. The check sheets supported the youth's statements of being locked in their room for most of their waking hours. The visual check sheets revealed youth were only out of their rooms for an average of five to seven hours a day and according to the master schedule, youth should be out of their rooms participating in activities for fourteen hours a day. Documentation revealed the program is not following the master activity schedule on the weekends and youth are not receiving structured activities for a minimum of sixty percent of the youth's awake hours.
A review of the master control logbook reflected the staff-to-youth ratio was met each weekend; however, logbook entries confirmed the master schedule was not followed and at times youth are being locked down in their rooms. The logbook entries indicated youth were locked in their rooms, but it did not list a reason why. Two of seven interviewed staff added additional comments to the reviewer requesting the program add more structured activities for the youth to participate in when not in education classes.

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

The program has a policy and procedures which provides interventions and instruction focusing on developing life and social skill competencies to youth through classroom and group instruction, hands-on experiences, and role modeling by staff and program administrators. Youth receive life and social skill intervention services specifically addressing at minimum: communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking to include problem-solving and decision-making. The program provides groups and curricula including, SAVVY Sisters, Teen Relationships, Girls in Real Life Situations (G.I.R.L.S.), Thinking, Feeling, and Behaving, Social Success, Therapeutic Art, and Dialectical Behavior Therapy (DBT) groups. A review of the program's contract indicates the program has staff trained to provide all the required life skills and intervention groups, as well as their mental health and substance abuse treatment groups. A review of group sign-in sheets confirmed the program is providing all contractually required groups to youth according to the activity schedule. A review of seven youth case management records showed all youth are participating in life and social skills groups and training, as required. Interviews with the facility administrator (FA) and clinical director indicated youth attend delinquency, social, and life skills groups daily and are provided an opportunity to practice these skills during their daily routine. Interviews with seven youth indicated they are all currently participating in several groups to include, but not limited to, Thinking for a Change (T4C) and anger management. All youth interviews also revealed the youth learn active listening skills, coping skills, and utilize role playing to model desired skills. All seven interviewed youth indicated they have been able to use the skills they have learned in their daily routine.

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 provides delinquency interventions through evidence-based principles and practices of restorative justice. The evidenced-based interventions are designed to reduce the influence of risk factors related to re-offending behavior. The program provides Impact of Crime (IOC) groups twice a week (Tuesday and Thursday) in the evenings, in addition to community service projects which helps to increase awareness and empathy for crime victims and survivors. A review of staff training records showed three staff are trained to facilitate IOC. A review of seven case management records showed one youth is participating in the current IOC group cohort. The other six youth are scheduled to begin IOC on September 24, 2019 when the new cohort begins. In an interview, the clinical director stated youth are prioritized in groups depending on their individual risk factors and needs. In an interview, the facility administrator (FA) stated youth watch a video of several victim speakers, along with in-person victim speakers, to help expose youth to a victim's perspective. According to the FA, youth have also participated in service projects with Keep Tampa Bay Beautiful Beach Clean-up, Feeding Tampa Bay, the Humane Society, Adopt-A-Road road clean-up, and planting flags for all the victims of the September 11, 2001 terrorist attacks. A restorative justice awareness group and/or activity was unable to be observed during this annual review. Interviews with seven

youth indicated they are all currently participating in several groups; however, only one youth specifically indicated IOC, while six others indicated daily groups/groups. All seven interviewed youth indicated they have been able to use the skills they have learned in their daily routine

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 which address gender-specific programming for a female population, pursuant to the contract. The program follows the Girls 4 Success model, which identifies signature strengths such as volunteer and family focused services, in addition to therapeutic support, health and wellness, academic and life skill services. To impact positive outcomes for girls, the program creates a therapeutic milieu where all programming creates a culture which values the developmental differences of girls and embraces their life experiences. The program utilizes several gender specific treatment and social skill curricula to include: VOICES, SAVVY Sisters and Girls in Real Life Situations (G.I.R.L.S). These group models focus on needs specific to the female population served by the program. Interviews with the facility administrator (FA) and clinical director were interviewed. The FA states the program follows the girls matters gender responsive philosophy and the program provides youth with personal items which allow gender expression, to include meeting the needs of a youth which may identify as the opposite gender. The clinical director's interview verified the gender specific programming and milieu in place in addition to the review of group sign-in sheets. Seven youth were able to discuss the various groups and activities they participate in and the skills they have learned. Interviews with seven youth indicated they are all currently participating in several groups to include but not limited to: VOICES. All seven interviewed youth indicated they have been able to use the skills they have learned in their daily routine.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Limited 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 to address the provision of an internal alert system. The program's policy addresses the practice of entering and updating alerts in the Department's Juvenile Justice Information System (JJIS) by appropriate staff. The internal alert system is designed to document each youth's applicable diagnosed medical conditions, allergies, psychotropic medications, food/diet restrictions, mental health risks, gang affiliations, and security and safety risks. Staff can review all internal alerts on the alert board located in the staff break room. Internal alerts are also discussed before each work shift through debriefings. The internal alert system is updated by designated staff in security, medical, or mental health

departments. Seven reviewed youth medical, case management, and mental health records contained documentation supporting alerts were reviewed, verified, and entered into JJIS and the internal alert system by an approved designee. All reviewed youth alerts were documented in the logbooks when required. Four of seven reviewed youth records contained previous suicide risk alerts. In twelve out of seventeen youth suicide risk alerts, the youth suicide risk alerts were closed late. In ten of twelve late closed suicide risk alerts, the alerts were closed over two weeks late and in four instances, over a month late. In two of the twelve late closed suicide risk alerts, the alert was closed five and seven days late respectively.

An interview with the facility administrator revealed internal alerts are tracked and reviewed daily, and leadership from various departments are responsible for managing alerts applicable to their department. All internal alert trackers are reviewed on a weekly basis during morning management team for fidelity monitoring. Seven staff were interviewed and confirmed the practice of being briefed of all alerts during daily shift briefings, as well as the internal alert board in the breakroom.

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

The program maintains an individual youth case management record and an individual healthcare record (IHCR) for all youth in the program. The program also maintains an active mental health and substance abuse record, separate from the IHCR, during a youth's on-going program stay. Prior to discharge, the mental health and substance abuse record is merged into the IHCR. Records for seven youth were reviewed. All records were marked "confidential" and secured in locked cabinets within a locked office/file room. All case management records complied with the file tab requirements.

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

The program has a process to promote constructive input from youth. The program maintains a youth advisory board comprised of youth enrolled in the program, giving youth the opportunity to have verbal contact with the program's administration regarding program operational issues, complaints, and/or suggestions. Additionally, the program utilizes Chatty Cathy forms, daily meetings, closing circle, and monthly community circle meetings which gives each youth an opportunity to address both positive and negative issues they may have. The annual compliance review team observed a daily meeting where youth, staff, and administration were present, and youth discussed concerns and suggestions with each other and staff/administration. Daily meetings with youth were documented on the daily schedules. The youth advisory board meets weekly with administration; however, documentation revealed the program did not have a youth advisory board meeting between April and July 2019, due to no youth meeting the minimum qualifying level in the behavior management system (grace or elegance) to participate on the youth advisory board. Youth advisory board meeting minutes and sign-in sheets for August and September 2019 were reviewed. Each meeting followed an individual agenda which addressed each request or complaint accordingly, either during the following week's youth advisory meeting or with program leadership. Some topics discussed

during the youth advisory board meetings included dietary issues, living area concerns, incentive calendar input, and activity ideas.

Seven interviewed youth reported they can provide feedback and input if desired through the daily meeting or submitting a Chatty Cathy. Two of the seven interviewed youth added the youth advisory board as part of the process. An interview with the facility administrator reflected youth can provide input by daily meetings, a Chatty Cathy, grievances, youth advisory board, and monthly community circle meetings. Community circle meetings are facilitated by staff and youth to address bigger issues which may be developing between youth themselves.

1.17 Advisory Board	Limited 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 for maintaining a community advisory board. The program has an advisory board in conjunction with Hillsborough Girls Academy and Tampa Residential Facility, which are all located on the same compound. The program maintains a list of community advisory board members from the school board, law enforcement officials, community partners, faith-based organizations, a local mentoring agency, judiciary, business community, victim advocates, and parents/guardians of former/present residents. Reviewed documentation for the past six months reflected the program's community advisory board met on May 16, 2019. According to the provider's regional compliance manager, the program did not attend the scheduled meeting in August 2019 due to an altercation at the program; therefore, the program did not have a meeting at least every ninety to 120 days during the annual compliance review period. A review of the meeting minutes reflected each program was separately discussed during the meetings. There was clear documentation to support the program made attempts to schedule meeting dates and work around community advisory board member's schedules by the program's facility administrator (FA) mailing a letter, in advance of the scheduled meeting to increase attendance. Attempts were clearly made for recruitment efforts from law enforcement, the judiciary community, other community partners, business community, school board, faith community, victim advocates, and parent/guardians. Reviewed community advisory board agendas and meeting minutes documented the program provides the board members with information regarding program updates, community updates, and giving back to the community. The annual compliance review team attempted to interview an advisory board member, but the two advisory members did not respond to voicemail messages left by the review team. In an interview, the FA indicated the program has a quarterly board meeting with two other local programs. Meetings are usually conducted in the Tampa training academy building at 11:00 a.m. and the board provides resources and support to the program. The FA indicated the board has invited program youth to community services events and provided services to youth at the program. The FA further stated a binder is maintained with meeting letters, recruitment efforts, and meeting minutes.

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

The program conducts monthly all staff meetings, monthly supervisor meetings, and daily morning management meetings to share information with staff and to enhance program planning. A review of the program's meeting binders indicated meetings are held monthly or daily and were held accordingly during the annual compliance review period. A review of the all

staff meeting minutes indicated the program reviews with staff red flag issues, medical updates, mental health updates, drill reviews, human resources issues, policy reviews, and safety and security issues. A review of the daily management meetings indicated the management team discussed programming issues, grievances, Central Communications Center reports, incident reports, youth issues, education issues, Protective Action Response (PAR) incidents, program trends, alert trackers, sick calls, and staff vacancies. Monthly staff meeting documentation did not reflect a review of the annual compliance report and/or the Comprehensive Accountability Report (CAR). The program also conducts parent/guardian surveys upon each youth's admission and discharge from the program, and a random sample of youth and parent/guardian surveys on a quarterly basis. The feedback received from the surveys is discussed with administration and used to enhance programming.

The program has a policy and procedures in place for employment recognition. The purpose of the policy is to recognize employees for their contribution to the program through their performance to create a culture of care. The program has an employee morale committee which meets monthly to determine ways to increase employee morale, cohesion, and staff retention. Recently the committee ordered shirts for all staff. The program also utilizes a program called the TrueCore Way for staff members going above and beyond, which allows supervisory staff or customers to recognize employees for exemplifying the TrueCore Way. During an interview with the facility administrator (FA) and regional compliance manager, it was confirmed the program holds monthly staff meetings, monthly supervisor meetings, and daily management meetings to keep staff informed of events going on in the program. The FA stated staff can provide input during all meetings, through the employee morale committee, and through the staff input box located in the staff breakroom. The monthly morning meeting dashboard also helps to provide data for program planning. The regional compliance manager indicated youth and parent/guardian surveys are conducted quarterly and the information collected is shared with staff and used to improve programming.

Seven interviewed staff members confirmed the program holds monthly staff meetings, daily shift briefings, and management meetings. The seven staff indicated youth behavioral issues, training, youth alerts, program trends, drills, and department related topics are discussed during monthly staff meetings. Two out of seven interviewed staff indicated they had received information concerning parent/guardian and youth surveys or annual compliance reports. Two of the interviewed staff indicated communication within the program was poor or very poor, three staff indicated communication was fair, and two staff indicated communication was good or very good. Five of the seven interviewed staff commented on communication breakdowns between administration and direct care staff. Several staff stated the communication between administration and floor staff is not effective. One of the seven staff stated staff do not communicate to administration because they feel their concerns and issues go unresolved, so they tend to retaliate by calling out from work. Another staff admits communication has improved between the departments, but they have experience with not being on shift on weekends and coming back on Monday to an email debrief. One staff stated they were not aware they had the opportunity or option to voice their input.

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 addressing the evaluation of staff performance. Performance evaluations are completed annually for all staff by department heads. In an

interview with the facility administrator (FA), it was reported ninety-day evaluations are completed while a staff member is on probation and then annual evaluations thereafter. Annual evaluations are completed to provide feedback to staff regarding their performance over the prior year to include implementation of the positive performance system (PPS) and their overall specific job duties. Goals are also identified for the upcoming year. Each staff is also given the opportunity to provide comments and written input during this time. Performance evaluations address performance standards to include job duties, job knowledge and competency, teamwork, professionalism, and goals achieved. Evaluations are explicit to different categories of staff positions. Staff can be rated as commendable, acceptable, needs improvement, unacceptable, or non-applicable. Each performance evaluation provides an overall numerical rating at the end of the evaluation. Seven personnel records were reviewed. Each included the specific job description and applicable performance evaluation. There was one key position vacant at the time of the annual compliance review. The key position is for a full-time certified behavior analyst. This position has been vacant since August 1, 2019 when it was added to the contract.

Seven staff were interviewed about how often they receive a formal evaluation of their performance. Five of the seven staff were hired after January 2019. None of the staff indicated they had received an annual performance evaluation or were aware of annual evaluations, one staff indicated performance evaluations are completed every sixty to ninety days, two staff indicated evaluations were completed monthly, one staff stated evaluations were completed every ninety days, and one staff indicated evaluations were completed every two to three months. Two out of seven interviewed staff indicated they have never received a staff performance evaluation.

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

The program's activity schedule was reviewed along with the program's policy and procedures regarding recreation and leisure activities. The program has a range of supervised and structured indoor and outdoor recreation activities available to youth. Activities include basketball, yoga, board games, hula hoop, calisthenics, fitness challenges, jump rope, therapeutic art, and chalk drawing. The program currently has one recreational therapist in accordance with the contract. The education and qualifications of the recreational therapist was reviewed. The therapist has a bachelor's degree in recreation and sports management which meets the contract requirements. A review of the logbook reflected a minimum of an hour of recreation activity is provided daily for all youth. The youth have wellness plans and updates on the progress of those plans are provided to the treatment team monthly. The recreation therapist does not attend treatment team meetings but provides the information about the wellness plan program to the team prior to the meeting. Youth are provided an opportunity to provide input into the rules and operation of the program through the youth advisory board, daily meetings, and Chatty Cathy's. The recreation therapist contacts master control prior to outdoor recreation time to determine if heat index is too high or there are other weather conditions which could cause illness or physical injury prior to going outside.

Seven interviewed youth indicated they are provided a variety of activities with varying degrees of mental and physical exertion throughout the day. Seven interviewed youth and seven interviewed staff indicated youth are provided with at least one hour of large muscle activity each day. During an interview with the recreation therapist, it was indicated the recreation activities promote community wellness which allows youth to contribute to the group culture,

promotes social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The review team observed recreation time during the annual compliance review. Recreation time included basketball, hula hooping, jump rope, tug of war, sidewalk chalk drawing, and a “poetry slam” where youth were able to recite original poems given participation certificates.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures in place for initial contacts to parents/guardians and court notification. Seven youth case management records were reviewed. Each record included supporting documentation indicating each parent/guardian was contacted by phone within twenty-four hours and a mailed written notification of the youth's admission within forty-eight hours. The program is required, upon a youth's admission, to submit a notification within five days to the committing court. All seven records contained same day of youth admittance to the program notification to the court, juvenile probation officer, and post-residential services counselor, if applicable.

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

The program has a policy and procedures for youth orientation. Seven youth case management records were reviewed, and each contained supporting documentation of a completed youth orientation on the same day of admission. The program utilizes an orientation checklist to ensure all required topics are discussed with the youth. Each of the seven youth was provided a youth handbook specifying all the essential elements, as outlined in the Florida Administrative Code and the program's policy. Each youth was assigned a living unit room during their classification meeting upon admission. There were no admissions scheduled during the annual compliance review; therefore, the program's orientation process was not observed. Seven youth were interviewed. All youth reported having an orientation completed within twenty-four hours of admission to 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.	

Seven case management records were reviewed and three were applicable for youth who were over the age of eighteen. Documentation for each of the three applicable records indicated the program had written consent before discussing physical or mental health screenings, assessments, education, or treatment with the youth's parent/guardian or any other individual for the duration of the youth's stay.

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 for classification factors, procedures, and reassessments for activities. The program procedures include utilizing a standard classification form designed to identify essential information for appropriate assignment of a youth to a living unit, sleeping room, and youth group or staff advisor. This form highlights the youth's demographics, physical characteristics, maturity level, and identification or suspected risk factors for suicide, medical, escape and/or security. Seven youth case management records were reviewed. Each youth record contained a documented completion of a classification meeting and form on the day of admission to the program. The Department's Juvenile Justice Information System (JJIS) alerts were reviewed. Each youth was applicable for identified or suspected risk factors. All medial, mental health, substance abuse, and security alerts were recorded in the program's internal alert system. Additionally, each youth alert corresponded with their respective classification form and entered into JJIS. All seven youth had a Victimization and Sexually Aggressive Behavior Screening (VSAB) completed in JJIS upon intake and maintained in their respective record.

The program policy requires the completion of a risk assessment monthly, which is facilitated during the youth's monthly treatment team meeting. During the annual compliance review, observations of three treatment team meetings confirmed the program's practice. A review of all seven youth case management records included supporting documentation of completed risk assessments. Each reviewed risk assessment outlined the youth's eligibility to participate in work projects and off-campus activities. Youth at the program do not participate in work projects involving tools. One of the seven youth was applicable for eligibility to participate in an off-campus activity. Two additional youth case management records were reviewed to confirm program practice in completion of a risk assessment prior to youth participation in an off-campus activity. A risk assessment was completed for each of the three youth as required. An interview with the facility administrator was conducted which revealed identified risk and suspected factors from the classification meeting, and VSAB results are considered when assigning a youth to a room. Occurrences for a youth room reassignment requires a reclassification implemented to place youth appropriately.

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 for gang identification and notification to law enforcement. Seven youth case management records were reviewed, which one was applicable for gang-related involvement. The program provided two additional youth records identified in gang related activities. All three records included written gang involvement notifications to local

law enforcement, the educational provider, and youth's juvenile probation officer upon identification. The Department's Juvenile Justice Information System (JJIS) alerts were reviewed, all three youth alerts regarding their gang affiliation status were included.

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 for gang identification: prevention and intervention activities to ensure youth have an opportunity to develop a plan to dis-affiliate with a criminal street gang. The program provided seven case management youth records. One of the seven case management youth records provided was applicable for gang affiliation; therefore, two additional youth records were reviewed. All three applicable records had a performance plan which included a gang intervention goal. Two of the three records reviewed had documentation to support the youth were currently working on gang intervention strategies. The third record reviewed had documentation to support the youth had been provided gang assignments but had not begun working on them, and is set to participate in the next Impact of Crime cohort beginning September 24, 2019. The program utilizes three gang intervention curricula: ARISE curriculum: Gangs: 50+ Stories of Fractured Lives, gangs 101-Understanding the Culture of Youth Violence and Impact of Crime. The program indicated they use the Changing Course-Preventing Gang Membership book in their prevention efforts. This book was published in partnership with the National Institute of Justice and the Centers for Disease Control and Prevention.

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

The program has a policy and procedures in place to address completion of a Residential Assessment for Youth (RAY) assessment and reassessment. The Department launched a new assessment tool entitled RAY. The previous assessment tool utilized was entitled Residential Positive Achievement Change Tool (RPACT). The RAY took the place of the RPACT in the Department's Juvenile Justice Information System (JJIS) for program access on May 6, 2019. A Department mandate for all programs was initiated requiring for each youth admitted to a program after April 8, 2019, to have a RAY completed. The program is required to complete initial assessments for each youth within thirty days of admission. Seven youth case management records were reviewed, revealing six were applicable for completion of an initial RAY and one youth applicable for an initial RPACT. All seven initial assessments were conducted in advance of the required timeframe and maintained in JJIS. The program completes a RAY reassessment every ninety-days after completion of the initial assessment. Six out of the seven youth were applicable for a RAY reassessment. One of the seven youth was not due for a reassessment. Five of the six eligible RAY reassessments were completed within the required timeframe with one exception; one youth's RAY reassessment was

completed four days late. All six applicable youth RAY reassessments were maintained in JJIS with a copy filed in each youth's official case record.

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

The program has a policy and procedures to ensure a Youth Needs Assessment Summary (YNAS) is completed within thirty days of a youth's admission. Seven youth case management records were reviewed. Each record contained a YNAS completed within the required timeframe and documented in the Department's Juvenile Justice Information System.

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

The program has a policy and procedures to address the individual performance plan development, goals, and transmittal. The program policy requires within thirty days of a youth's admission an individualized performance plan (IPP) is to be developed. Seven youth case management records were reviewed. Six out of seven youth records contained an IPP developed within the required timeframe. The remaining youth's IPP was completed four days late. Each IPP included input from the treatment team leader, administrative representative, living unit representative, educational and treatment staff, youth and, if applicable, a Department of Children and Families (DCF) case worker. None of the youth had a support coordinator from the Agency for Persons with Disability. All seven youth's respective IPPs included supporting documentation of all parties' signatures present during the treatment team meetings. One of the seven youth's IPP was missing the dates of attendee's signatures. All seven records contained a notation regarding a copy of the IPP mailed to parent/guardian and two applicable DCF case workers with a request to return to the program with the signature page signed. One of the seven youth's IPP signature pages was returned signed. Each youth's IPP included goals based on the top three criminogenic needs and specific delinquency interventions with measurable outcomes. Three out of seven youth's IPPs included targeted court-ordered sanctions. Four youth initial plans did not include targeted court-ordered sanctions; however, the program identified the missing sanctions on each youth's IPP and added it prior to the annual compliance review but after the completion of the IPP. Only one was added the week before to the review, the remaining goals were added one to three months ago. All seven IPPs included responsibilities of the youth and staff to accomplish the goals and target dates for goal completion. The program is required to provide a copy to the youth and forward a copy to each

youth's parent/guardian, and/or the DCF case worker, juvenile probation officer (JPO), and committing judge within ten days. All seven youth records included documentation to support a transmittal letter was sent to the parent/guardian, DCF caseworker, committing court, and juvenile probation officer within the required timeframe. Seven youth interviews were completed, which revealed each youth's ability to articulate their current performance plan goals. Six of the seven interviewed youth reported they had a copy of their performance plan.

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

The program has a policy and procedures for individual performance plan (IPP) revisions. Seven youth case management records were reviewed, which revealed six were applicable for a ninety-day IPP reassessment. All six youth's IPP revisions were implemented due to newly acquired/revealed information; in addition, to demonstrating each youth's continuance in working on the same top three criminogenic needs identified in the IPP. Each youth's IPP was updated and completed within the required timeframe.

None of the seven youth were in a transitional phase of the program; therefore, three closed youth case management records were reviewed. Each of the records included supporting documentation regarding initiation of transition activities on the youth's IPP within the last sixty days at the program.

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 for performance summaries and transmittals. Seven youth case management records were reviewed, which revealed six were applicable for a ninety-day performance plan review. All six records included a completed performance plan review within the required timeframe. Each youth's respective performance reviews included the status of each performance plan goal, youth's overall treatment progress, youth's academic status, youth's behavior, level of motivation/readiness to change, interaction with peers, interaction with staff, overall behavior adjustment, and significant positive and negative events if applicable. None of the records were applicable for an updated performance plan due to release, discharge or transfer from the program. No youth were eligible for a justification for release request during the annual compliance review period.

Three of the six youth performance summaries indicated provision of an opportunity to provide feedback. The comment section was left blank in three of the summaries reviewed. Each of the six youth records indicated provision of a copy of the performance summary, and the original summary filed in their case management record. Each performance summary was signed by all

designated parties. A copy of each youth's summary was mailed out to all required parties within ten working days. None of the reviewed records required victim notification nor were they identified as being in the Sexually Violent Predator Program. Three closed records were reviewed for release summary contents. In all three closed records, an original summary, along with justification for release and the pre-release notification, were sent to the juvenile probation officer assigned at least forty-five days prior to the youth's planned release. Signed copies of the summaries were retained in each of the records reviewed. Each youth's record included an updated copy of a Residential Assessment for Youth exit assessment upon approval of the Pre-Release Notification.

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 for parent/guardian involvement in case management services. Seven youth case management records were reviewed. The program documented all parents/guardians and two applicable Department of Children and Families (DCF) case workers contact attempts through mail and phone for involvement in the case management processes. A document review of all seven youth records indicated the parents/guardians and DCF case workers received advanced notice through mailed letters regarding inquires for participation in program reviews, formal treatment team meetings, and performance plan development. The program recreation therapist sends out invitation letters to the parent/guardians informing them of family days. A review of all seven youth case management records included copies of an Individualized Performance Plan (IPP) mailed to each parent/guardian and DCF case workers with a request for signatures and a return back to the program. One out of the seven youth IPPs signature pages was returned signed. All required attendees were present for meetings.

During the annual compliance review period, three youth formal treatment team meetings were observed. All three meetings included parent/guardian participation by telephone. If the parent/guardian is unable to attend a meeting, the program provides them with an opportunity to give verbal and written input ahead of the meeting, and/or participate by phone. An interview with the facility administrator (FA) confirmed the program's encouraging processes for parent/guardian participation in case management services. The FA notes parent/guardian involvement in the admission process, admission classification meeting, youth needs assessment, monthly youth treatment team meetings, and weekly phone calls. Seven youth were interviewed, which revealed each youth's parent/guardian and DCF worker is involved in case management services including monthly treatment team meetings and weekly phone calls.

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

The program has a policy and procedures in place for members of treatment team. During the annual compliance review, an observation of three treatment team meetings and a review of seven youth case management records determined all required members were a part of each youth's treatment team. All seven youth records included supporting documentation of the youth's parent/guardian, Department of Children and Families (DCF) case worker (if applicable), and juvenile probation officer (JPO), and all meeting attendees were invited and encouraged to

participate through advance notification. The program sends out reminder of meeting letters to each youth parent/guardian each month, and designated meeting attendees receive email notification regarding the treatment team schedule. The members include the youth, parent/guardian, recreation therapist, juvenile probation officer (JPO), a living unit and administrative representative, mental health therapist, gang prevention specialist, transitions services manager, treatment team leader, and educational and clinical staff. One of the three observed treatment team meetings included a youth in transition, and the transition service manager was present for the meeting. One of the three treatment team meetings observed was a gang affiliated youth. The program's director of case management is identified as the program's gang prevention specialist and was present for the meeting.

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

The program has a policy and procedures for the incorporation of other plans into individual performance plans (IPP). Seven youth case management records were reviewed. Four out of seven youth records referenced additional plans to include academics and treatment plans. Three of the seven case management youth records did not reference additional plans in the initial IPP; however, the program acknowledged the findings and revised all three records prior during the week of the annual compliance review. Two of the seven youth are in the custody of Department of Children and Families (DCF) and their care plans were referenced in each of their IPPs. The program noted there were no youth receiving services from Agency for Persons with Disabilities.

2.15 Treatment Team Meetings (Formal and Informal Reviews)	**Satisfactory Compliance**
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include 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 to address formal and informal treatment team reviews. Seven youth case management records were reviewed. Each record demonstrated meeting the timeframe requirement with facilitation of a formal treatment team meeting every thirty days and an informal treatment team meeting bi-weekly, each month. Each youth's formal and informal performance reviews included the youth's name, date of review, comments from treatment team members, a brief synopsis of the youth's progress, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions (when applicable), treatment progress, and Residential Assessment for Youth (RAY) reassessment results (when applicable). Each youth was provided an opportunity to demonstrate their skills by leading their treatment team meeting. Observations during three treatment team meetings found verbal input by education was provided prior to start of the meeting; however, all required staff were present during the meetings. Through the observation of treatment team meetings, the youth presented the following information: progress of performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, and a demonstration of acquired skills. All members of the treatment team meetings were engaged and actively participated in the meeting. An interview with seven youth was completed. All seven youth reported staff review their performance to include progress on performance plan goals, positive and negative behaviors, and treatment progress. Each youth reported they are

provided an opportunity during treatment team meetings to demonstrate any skills they have learned in the program.

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

The career education programming at this program is a Type 2 and the services are appropriate based upon the age, assessed educational abilities and goals of the youth being served in the program. The career education program provides youth with employability skills, such as completing an employment application and developing a resume summarizing their education, work experience, and/or career training. The Daniel Memorial Institute Independent Assessment tool is used to enhance youth communication, interpersonal, employability, independent living skills, and decision-making skills. In an interview, the lead educator indicated they use the Personal and Career Studies curriculum offered by Hillsborough County Public Schools. The Project Promise is a partner with Hillsborough County Public Schools and is monitored by the school district. Project Promise provides special programs and services to meet the unique academic needs of youth who are at-risk such as student-oriented legal workshops, motivational seminars, academic and vocational success coaching and training in goal-setting, decision-making, and leadership skills. Project Promise also sponsors and funds the following programs utilized: G3 Life Applications, LLC, Inner City Advocates Corporation, NOMODRAMA Inc, A&J and the Faith Consulting Group. Three closed youth case management records were reviewed and all three contained supportive documentation enclosed with employability or continuation of education as one of their goals at the time of release from the program.

2.17 Educational Access	Failed 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 Hillsborough County Public Schools provides educational services and approved instruction schedules on a 250-day calendar for youth in the program. The educational program is on a block schedule of six class periods, fifty minutes each, to total 300 minutes of daily instruction, and a minimum of twenty-five hours of instruction weekly. Youth received credits earned for the education courses and career training experiences while in the program. Seven youth were interviewed and two stated there are a lot of interruptions during educational instruction and five stated there are not many interruptions. During an interview with the lead educator, it was stated the educational instruction schedule is consistently followed. The annual compliance review team members reviewed program documentation and logbooks from July 24, 2019 to August 23, 2019. During testing dates, the documentation did not show how many minutes of education the students not testing received. The documentation revealed youth missed the first period of school almost daily. For three of the days reviewed, the facility shift logbook did not record when school resumed or when school ended after lunch, and the time of education instruction could not be calculated. None of the dates reviewed showed the youth received 300 minutes of educational instruction. As an example, the facility shift logbook recordings indicated at least three days when the youth received less than 150 minutes of instruction and three days when the youth received less than 250 minutes four days when they received less than 280 minutes, and five days when they received less than 200.

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

Three closed case management records were reviewed for education transition plans. Services and interventions were written based on the youths' assessed educational needs and post-release education plans. Each record had evidence of responsible participants who were diligently involved and advocating for the youth to receive the provision and support services upon release. Youth from the closed case management records earned a cardiopulmonary resuscitation (CPR) certificate, and two of the youth earned their General Equivalency Diploma (GED), continuing education in post-secondary school or career opportunities. Each of the transition plans contained all required elements.

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

The program has a policy and procedures in place ensuring the intervention and treatment team planning for the youth's transition back to their community upon release. Three closed youth records were reviewed. Each of the three records confirmed transition conferences were held at least sixty days prior to youths' targeted release date and included all required parties. All records contained evidence of the transition conference addressing the performance plan and identifying the additional activities and services, as needed. Target completion dates and person responsible for their completion were identified. Transition plans were dated and had signatures which served as an acknowledgement of the activities and accountability. Each of the records documented an invitation to the youth and the case manager to participate and attend the Community Re-Entry Team (CRT) meetings. Two youth transition conferences were observed during the annual compliance review and the following treatment team members participated: the nurse, clinical director, case manager, assistant facility administrator, transition services manager, and the youth. The parent/guardian and juvenile probation officer participated in person or by telephone. A copy of each plan was sent with a request for return with signature to anyone not in attendance who had a responsibility for completion of transition goals. In all three records, the plan was transmitted to the JPO with an email acknowledgment attached.

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.	

Review of three closed youth records documented the exit portfolio was addressed in the transition staffing and the program maintained a copy of the transition plan. Three records had a calendar with all dates/times/locations of follow-up appointments in the community and a copy of a state-issued identification (ID) card and birth certificate. One of the three exit portfolios contained a copy of the youth's social security card, the other two youth's parents/guardians refused to provide a copy of the youth's card. Two of the three records showed the youth obtained their General Equivalency Diploma (GED) prior to release. Two of the three portfolios contained education records and school transcripts. The third youth completed the GED prior to coming to the program and her previous education records and transcripts were not received by the program. All three portfolios contained resumes, and sample job applications. In the three records reviewed, documentation showed the exit portfolio was verified at the exit conference, given to the youth upon release, and forwarded to the JPO. All three records confirmed education staff forwarded a copy of the portfolio to the receiving school district and a copy was also given to the youth upon release.

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

In all three reviewed records, documentation indicated each youth participated in an exit conference at least fourteen days before their scheduled release. The juvenile probation officers (JPO) were notified of the youth's releases, which was documented in the youth records, as well as the dates, signatures, and summaries of pending transition goals. In all three records, the parents/guardians, intervention and treatment team leaders, and education representatives participated in the meetings and the status of transition activities were finalized for the youth's releases. All three records had the date of admission and the date of termination documented in the case record, which correlated with the dates in the Department's Juvenile Justice Information System. Two youth transition conferences were observed during the annual compliance review; however, no exit conferences were conducted during the week of this annual compliance review.

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 licensed mental health clinician (LMHC) who serves as the designated mental health clinician authority (DMHCA). The DMHCA is employed full-time by the program and is on-site at least forty hours a week. They are also available twenty-hour hours a day, seven days a week in the event of a mental health or substance abuse emergency. A review of the DMHCA's license found it to be clear and active, with an expiration date of March 31, 2021. An interview with the DMHCA reflected they are responsible for ensuring the timely and accurate completion of the required assessments, evaluations, and treatment plans. In addition, the DMHCA ensures the treatment programming at the program complies with all requirements outlined in the program's contract. The program will utilize the regional clinical director, who is a licensed mental health counselor, and the assistant clinical director to provide coverage in the absence of the DMHCA for the program. A review of their licenses found both are current and active, and do not expire until March 31, 2021.

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

The program has one licensed clinician who is the designated mental health clinician authority (DMHCA) for the program. The program will utilize the regional clinical director, who is a licensed mental health clinician (LMHC), and/or the assistant clinical director, who is also a LHMC to provide coverage in the absence of the DMHCA for the program. The program also has a licensed clinical social worker (LCSW) who provides services for youth in the program. A review of records found another LMHC who assisted in the completion of groups during this annual compliance review period. A review of the licenses for all LMHCs and the LCSW found they were all current and active, and do not expire until March 31, 2021. The program also contracts with a school psychologist. The psychologist's license is current and active and does not expire until November 30, 2019. On August 1, 2019, the program had an amendment to their contract which added the requirement of a full-time certified behavior analyst (CBA) position. They have an active contract with a CBA to provide services. The contracted CBA is continuing to provide services on a part-time basis until the program fills the full-time position vacancy. The CBA's certification is clear and active and does not expire until February 28, 2021. The program is currently working to recruit someone to fill the position full-time.

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

The program has a policy and procedures to ensure metal health and substance abuse staff have the appropriate credentials. The program has four non-licensed clinicians who provide services to youth in the program. Schedules are staggered to ensure the program has clinical staff present seven days a week. During a review of youth mental health records, it was determined the program had another non-licensed clinician who assisted with group counseling during this annual compliance review period. Each of the non-licensed mental clinicians hold a master's degree in a relevant field of study. The program was able to provide documentation of twenty hours on-the-job-training in assessing suicide risk, mental health crisis intervention, and emergency mental health services for each of the non-licensed. The reviewed documentation also validated the administration of five Assessments of Suicide Risk (ASR) or crisis assessments conducted in the physical presence of a licensed mental health professional, which allows them to conduct ASRs and prepare them for approval by a licensed clinician. A review of direct supervision logs confirmed non-licensed mental health clinical staff were provided with at least one hour on-site face-to-face direct supervision by the designated mental health clinician authority each week they worked, with a few exceptions. The reviewed clinical supervision documentation found one non-licensed clinician did not receive supervision when group supervision was conducted on June 29, 2019 and on August 1, 2019. Additionally, two applicable non-licensed clinicians missed clinical supervision when the group supervision meeting was held on August 8, 2019. The review of documentation for these three sessions was unclear, and two of these sessions did not have an official sign-in log for attendance. The process for documenting their weekly clinical supervision has been made more thorough since this concern was identified.

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 which explains the comprehensive screening process which is conducted on each youth during the admission process. This is included in the youth's Comprehensive Plan for Mental Health and Substance Abuse Services. A review of documentation confirmed the program followed the procedures outlined in the policy. A clinician completes a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) on each youth as part of the admission process. The reviewed documentation in all seven records confirmed this assessment was completed on the day of admission by a clinician and was entered into the Department's Juvenile Justice Information System (JJIS). Each of the reviewed MAYSI-2 assessments were conducted by a trained staff. Reviewed documentation also confirmed all available information was reviewed. This is done through a review of the commitment packet information, and the following, when available: external comprehensive evaluations, the youth's face sheet (to include alert information), and the Community Assessment Tool (CAT). Each of the youth's MAYSI-2s indicated a need for further assessment, and each youth was referred for further evaluation using the Florida DJJ Mental

Health/Substance Abuse Referral Summary. Two of the youth had a "hit" on the MAYSI-2 in the category for suicide ideation. This was reflected on each of their referral summaries. Program practice is to complete an Assessment of Suicide Risk (ASR) on each youth as part of their admission to determine if there are any concerns which may not have been identified through completion of the MAYSI-2. Due to the specialized intensive mental health services provided by the program, the clinician also completes a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening, a University of Rhode Island Change Assessment (URICA) Scale, and a Simple Screening Instrument for Alcohol and Other Drugs (AOD) to assist with the program's classification process and to help develop initial treatment plan goals. Interviews with the facility administrator and designated mental health clinician authority (DMHCA) confirmed the program's admission process.

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 regarding the completion of a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation for each youth. Each of the seven reviewed youth mental health records included a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) which indicated a need for further assessment upon entry to the program. All seven records had a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation which was completed within thirty calendar days of admission. All evaluations were completed by a non-licensed clinician, and reviewed by a licensed clinician within six days of completion. Each reviewed assessment documented the methods of assessment, identifying information, screening procedures, presenting problem, family history, history of abuse/neglect/trauma, behavioral observations, physical health, developmental history, mental health, mental status exam, substance abuse history and treatment, social history, sexual history, vocational skills, independent living skills, strengths, needs, abilities, transitional planning, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, summary of clinical impressions, and treatment recommendations. The results of the Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation are used to help develop each youth's individualized treatment plan.

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.*	

Each youth is assigned to a treatment team on their day of admission. A review of seven case management records found the specific assignment of a case manager and a therapist to each youth on their classification form. The program's policy designates the remaining members of each youth's treatment team, which includes a member of program administration, a living unit representative, a nurse, education staff, and the parent/guardian, when applicable. The review of treatment team documentation confirmed the team consisted of all required members. The

mental health and substance abuse daily service progress notes for seven youth were reviewed. The progress notes were documented on a form which contained all the information found on the Department's Group Progress Note form. This review confirmed all seven of the youth received services as set forth in their individualized treatment plan, with one exception. None of the program youth attended groups on August 31, 2019. The regional clinical director indicated the staff responsible for facilitating groups this day received disciplinary action. The program provided a copy of the "record of written warning" given to staff responsible for not conducting treatment groups. Six of the seven youth had a copy of a properly executed Authorization for Evaluation and Treatment (AET) in their individual healthcare record (IHCR). The other youth was eighteen years old at the time of the review. Each of the seven reviewed records contained a signed Youth Consent for Substance Abuse Treatment form, and a signed Youth Consent for Release of Substance Abuse Treatment Records form. A review of all seven youth's mental health and substance abuse daily service progress notes, as well as group sign-in sheets, validated mental health groups had no more than ten youth present, and substance abuse groups had no more than fifteen youth present during any group sessions. During the annual compliance review, observations of a mental health treatment group also confirmed no more than ten youth were present in the group. The program has a license from The Department of Children and Families to provide outpatient treatment substance abuse services until April 2020.

An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides mental health and substance abuse treatment groups, family counseling, individual counseling, and psychosocial skills training. The DMHCA indicated treatment groups are conducted seven days a week, individual counseling occurs no less than once a week for each youth, and family counseling is scheduled monthly for each youth. All seven interviewed youth indicated they attend group treatment. Specific group curriculums mentioned were Voices, SAVVY Sisters, and substance abuse groups. Seven interviewed staff all indicated they do not facilitate mental health or substance abuse treatment groups.

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

Each of the seven reviewed youth mental health records contained an initial treatment plan which was completed on the day of admission. All were completed on a form which contained all the elements of the Department's Initial Mental Health/Substance Abuse Treatment Plan sample form and were signed by all treatment team members. All seven were completed by a non-licensed clinician and were reviewed by the designated mental health clinician authority (DMHCA), within ten days of completion.

All seven records also contained an individualized treatment plan which was completed within thirty days of admission. Each plan was signed by the treatment team members, to include the

non-licensed clinician who prepared the plan. Each of the plans were reviewed by the DMHCA within the required ten-day timeframe. All of the plans were completed on a form which had all required elements found on the Department's Individualized Mental Health/substance Abuse Treatment Plan sample form. The individualized treatment plans included any psychiatric services, including psychotropic medications and the frequency of monitoring by the psychiatrist, when applicable. Each of the youth had treatment plan reviews which were completed every thirty days, as required. A review of each youth's progress notes confirmed the youth were receiving the group, individual, and family counseling, as specified in their individualized treatment plans.

Three closed records were reviewed for youth released from the program. There was evidence the program completed a Mental Health/Substance Abuse Discharge Summary in each reviewed record. These plans were discussed and finalized at the exit conference for each youth. Reviewed documentation confirmed these plans were signed by and provided to the parent/guardian of each youth upon release. The mental health/substance abuse records, including the Mental Health/Substance Abuse Discharge Summaries, were sent to the assigned juvenile probation officers (JPO) within five days of each youth's release from the program. The reviewed documentation also confirmed each youth received a copy of their Mental Health/Substance Abuse Discharge Summary in their exit portfolio, which was provided to them upon their release from the program.

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's serves youth in need of intensive mental health services, borderline developmental services and intensive medical overlay services. A review of seven youth mental health records confirmed the program completes a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation for each youth within thirty calendar days of admission. Additionally, mental health treatment planning begins the day of admission for each youth through the completion of an initial treatment plan. Each youth will then have an individualized treatment plan completed to address their needs no later than thirty-days after admission. A review of progress note documentation reflected group therapy is conducted seven days a week, and family therapy is conducted at least monthly for each youth, when applicable. All daily therapeutic activities are conducted by the program's clinicians. The program has weekly visits by the psychiatrist, who is available twenty-four hours a day, and mental health crisis intervention is available, when needed.

The program employs a licensed mental health counselor (LMHC) who acts as the designated mental health clinician authority (DMHCA). The DMHCA is on-site five days a week to provide oversight for all services provided. The contracted psychiatrist is on-site one day a week to perform psychiatric evaluations and to conduct medication management visits, as needed. A review of group progress notes, program schedules, and youth interviews confirmed clinical staff were at the program seven days a week. Nursing staff are at the program twenty-four hours a day, seven days a week to address any concerns which may arise for the youth in the program. None of the therapist caseloads were found to exceed twelve youth. This was confirmed through an interview with the regional clinical director and the DMHCA.

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 contract with a licensed physician (MD) to provide psychiatric services. The psychiatrist's license is current and active, with an expiration date of January 31, 2021. Their backup is an advanced practice registered nurse (APRN), whose license is clear and active, with an expiration date of July 31, 2020. The program has a valid protocol in place which defines the duties the APRN can complete when filling in for the psychiatrist. A review of seven records revealed two of the youth were admitted on psychiatric medications. The program was able to provide one more applicable record for review. Program practice is for each youth, regardless of whether they require psychotropic medications, to be referred to the psychiatrist for an initial diagnostic psychiatric interview. A review of youth records confirmed each youth was seen by the psychiatrist within the required time frame. Each initial psychiatric diagnostic interview was completed using the program's initial psychiatric evaluation form, which contained all required elements, and incorporated page three of the Department's Clinical Psychotropic Progress Note (CPPN) form. Two other youth were referred to the psychiatrist for re-evaluation during their stay due to concerns which were identified by staff. The youth were seen within thirty days of the referral, and had a psychiatric evaluation completed by the psychiatrist using the CPPN. All required medication management appointments were completed monthly for each of the five applicable youth. All youth not prescribed any medications were seen by the psychiatrist every ninety days to monitor their progression in the program, and to see if any new needs may be presenting.

The program's contract and intensive mental health requirements indicate the psychiatrist must be on-site weekly to provide services to the youth. The agreement with the program states the psychiatrist will provide services on a weekly basis, and they must be available twenty-four hours a day, seven days a week. A review of psychiatric service logs found the psychiatrist, or the APRN on three separate occasions, were on-site each week during the previous six-month period. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the psychiatrist validated they provide services weekly. The psychiatrist indicated there is good communication with the program, and they have a meeting with all available clinical staff during each weekly visit. The psychiatrist indicated they have no concerns with the healthcare or other services provided at the program.

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

The program has a written suicide prevention plan detailing the program's suicide prevention procedures. The plan outlines how the program will safely assess and protect youth with elevated risk of suicide in the least restrictive means possible. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, level of

supervision, referrals, communication, notification, documentation, immediate staff response, and a review process. The plan was reviewed and signed by the facility administrator on December 25, 2018, and by the current designated mental health clinician authority (DMHCA) on September 3, 2019. The reviewed plans also reflected an earlier review which was completed by the regional clinical director on March 11, 2019.

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 suicide prevention plan in place which outlines the methods used for supervising, observing, monitoring, and housing for youth identified through screenings, review of available information, or staff observations as having suicide risk factors. A review of seven youth mental health and substance abuse records found each youth was screened for suicide ideation during their admission to the program. Two of the seven reviewed youth had a "hit" for suicide ideation on their MAYSI-2; however, it is program practice to conduct an Assessment of Suicide Risk (ASR) on each youth during the admission process, regardless of whether any suicide risk factors were identified. Each of the seven youth, five of whom had no risk factors, were evaluated during admission, confirming the program practice. Each of these youth had an ASR administered by a non-licensed clinician on the day of admission, and each were maintained on standard supervision. All ASRs were completed under the supervision of a licensed professional as evidenced by their signature. The review of the youth records revealed there were seven different placements of suicide precautions for five of the reviewed youth. Each of these incidences occurred after the youth's admission and were a result of staff observations. Each youth had an ASR completed within twenty-four hours of the youth being identified as at risk. Supervision for all the applicable youth was documented on a Suicide Precautions Observation Form. These forms were completed in their entirety, to include the identification of "safe housing areas." A review of each ASR reflected notification was made to the youth's parent/guardian and their assigned juvenile probation officer (JPO), regardless of whether the youth was maintained on suicide precautions or not. Four youth were immediately stepped down to standard supervision. In the other three instances, each youth was seen for a Follow-up Assessment of Suicide Risk (FASR) each day they were on precautionary observation, until the decision was made to step the youth down to close supervision. Each youth was stepped down to close supervision through the completion of a Mental Status Exam, per the program's policy. The documentation also reflected a conference with a licensed clinician, when completed by a non-licensed clinician, and the facility administrator/designee prior to reducing the level of supervision in each instance. This was clearly documented on each reviewed form, and the DMHCA signed the form the next time they were on-site, when required. During these youth's heightened placement, supervision was documented using Suicide Precaution Observation Logs and Close Supervision Logs. No lapses in supervision were observed on the reviewed logs. Documentation reflecting the placement status of the youth was found in the master control logbook, and in the Department's Juvenile Justice Information

System (JJIS) alerts. Five of the reviewed alerts in JJIS were not closed immediately as required and were not entered in to JJIS at least two weeks after the youth was removed from supervision.

Two youth of the seven reviewed youth records were for youth who were placed in secure observation during this annual compliance review period. One youth had more than five placements into secure observation. Three incidents were selected for review, in addition to the one for the other youth. The reviewed documentation for each of the four instances revealed placement was authorized by the DMHCA. The program has one room specifically used for secure observation. Each of the youth had a Health Status Checklist, completed by a member of the same gender, for each placement. The reviewed Suicide Precautionary Observation Logs reflected both the youth and room were searched prior to the placement. Each of the youth were on constant supervision while maintained in secure observation. Each youth had an ASR conducted within eight hours of placement. In each instance, the decision was made to remove the youth from secure observation and place them back on regular precautionary observation with constant supervision. Support services were provided, when applicable, and each step down was done after conferring with the facility administrator/designee and the DMHCA, when applicable. All placements and status changes for youth on any type of heightened supervision were found in the master control logbook and facility shift logbook.

The program has a suicide response kit in master control and in the medical clinic. Each kit was found to include a knife-for-life, wire cutters, and needle nose pliers. Interviews were conducted with seven staff regarding what they are responsible for if a youth expresses suicidal thoughts. All seven indicated they will notify the program’s clinical staff, while six indicated they will place the youth on precautionary observation. Another staff indicated they would document their supervision of the youth. The program’s suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, facility procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services.

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 review of seven youth records found five of the youth had been placed on suicide precautions which required the completion of Suicide Precaution Observation Logs. There were forty logs available for review for these youth. All logs were maintained for the duration the youth was on suicide precautions, and the staff documented the youth’s behavior in real time at intervals which did not exceed thirty minutes. Many of the logs were applicable for the documentation of warning signs. Each reflected warning signs documented after notification being made to the designated mental health clinician authority and the facility administrator/designee. Each of the reviewed Suicide Precaution Observation Logs also had all required reviews by supervisory staff and licensed clinicians. Clear instructions were provided for staff regarding how each youth should be supervised. This was documented on a restriction checklist. Additionally, the program prints the Suicide Precaution Observation Logs on orange

paper, making them more noticeable for staff. Informal interviews were conducted with three youth who had been on suicide precautions during their stay. Each of the youth indicated staff were with them always during this placement, and they were never left alone while on suicide precautions.

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

The program's suicide prevention plan addresses suicide prevention training. A review of seven staff pre-service and seven in-service training records found each staff received at least six hours of suicide prevention training. The program's mock suicide drills were reviewed since the last annual compliance review. This period included the first two quarters of calendar year 2019 and the current quarter, which is not over. Each of the drills included the time of the drill, the designated shift, name of the staff who conducted the drill, the nature of the incident, persons involved/function of each, type of medical of care given, type of mental health/crisis intervention provided, the outcome of the incident, the time of response, and any follow-up or corrective action needed. The review also found each drill had a sign-in sheet attached with the names and signatures of all staff who participated in the drill. The review of drills for the first quarter found five separate drills were conducted during the two shifts. Three of these drills were conducted by nursing staff, and each of these included a demonstration of cardio-pulmonary resuscitation (CPR). Twenty of the thirty-four applicable staff either participated in a suicide response drill or attended a staff meeting with a review of a drill during this quarter. Only twenty of the staff participated in a drill or had a review during a staff meeting during this quarter. The review of the second quarter found the program only conducted one suicide prevention drill during this quarter. It was conducted on the first shift. The review of drill and staff meeting documentation found only thirteen of the forty-four applicable staff either participated in a suicide response drill or had a review of drill information at a staff meeting during this quarter. Reviewed documentation for the present quarter reflects drills have been conducted with more frequency and on each shift. An interview with the regional clinical director revealed they will be reviewing the recent drill documentation with staff at a monthly meeting before the end of September 2019.

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 crisis intervention plan which has a main goal of responding to youth in crisis in the least restrictive method possible. This is done to protect the personal safety of the youth and others while maintaining control and safety of the program. The plan includes a notification and alert system, means of referral including youth self-referral, communication, supervision, and documentation and review of the crisis. The plan was reviewed and signed by the facility administrator on December 25, 2018, and by the current designated mental health clinician authority (DMHCA) on September 3, 2019. The reviewed plans also reflected an earlier review which was completed by the regional clinical director on March 11, 2019.

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.	

Two of the seven reviewed records were for youth who required a crisis assessment. One of these youth required two separate crisis assessments during their stay. In each instance, the youth were seen within two hours of being determined to be in crisis. Each assessment included the reason for the assessment, a mental status exam and interview, the determination of danger to self and/or others, clinical impressions, recommendations of treatment, supervision levels, and follow-up or further evaluation. Two of the reviewed assessments reflected the youth were stepped down to standard supervision upon completion of the Crisis Assessment. The third assessment indicated the youth was maintained on mental health alert status after completion of their assessment. Supervision for the youth was documented on a Mental Health Alert Log, which the program copies on blue paper for easy identification. The youth was stepped down to standard supervision after completion of a follow-up Mental Status Exam. The crisis intervention plan includes procedures for the notification of the youth's parent/guardian, which was completed for each of the reviewed assessments. All three assessments were either completed by a licensed clinician or a non-licensed clinician, followed by a review by a licensed clinician within the required twenty-four hour period.

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 detailed emergency care plan which addresses mental health and substance abuse emergency care. The plan was reviewed and signed by the facility administrator on December 25, 2018, and by the current designated mental health clinician authority (DMHCA) on September 3, 2019. The reviewed plan also reflected an earlier review which was completed by the regional clinical director on March 11, 2019. The plan contains all the required elements outlined in the Florida Administrative Code and includes the immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, staff training, and indicates they will review each incident.

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

The program has a detailed emergency care plan which addresses mental health and substance abuse emergency care. A review of seven youth mental health records found only one of these youth had been hospitalized pursuant to a Baker Act during this annual compliance review period. The program was able to provide documentation for another youth who had two instances of a Baker Act during her stay. A review of documentation found each was identified due to warning signs being exhibited while the youth were already on precautionary observation. The reviewed documentation confirmed notification was made to both the designated mental health clinician authority and the facility administrator/designee once the youth began exhibiting concerning behaviors. The youth were immediately placed on one-to-one supervision once the determination was made to transport the youth to a crisis stabilization unit. The program uses TransCare to transport youth, when authorized by the DMHCA/designee. Upon return from the crisis stabilization unit, each youth was maintained on one-to-one supervision until they could be seen for a new Assessment of Suicide Risk (ASR). Each of these youth were maintained on precautionary observation after the initial ASR and were stepped down following the program's policy and procedures. The program did not have to use Marchman Act procedures during this annual compliance review period.

Standard 4: Health Services

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

The program has a contract with a licensed physician, who acts as the program's designated health authority (DHA), and they are responsible for providing oversight and supervision for all health and medical services, including general supervision of all medical personnel. The DHA is responsible for the overall clinical direction, policies, and protocols for medical services at the program. A review of the Department of Health Medical Quality Assurance License search website revealed the DHA's license is clear and active in the state of Florida and expires on January 31, 2021. The DHA is scheduled to be on-site five times a week, and is on call twenty-four hours a day, seven days a week. A review of the medical sign-in/out-logs for the last six months confirmed the DHA was on-site five times a week, every week except one week when he was on vacation. The DHA uses the services of another licensed physician, as a back-up when they are unable to provide services to the youth at the facility. A review of the medical sign-in/out-logs indicated the back-up physician was on-site three days during the week the DHA was on leave, which indicates the program did not have a physician on-site for two days during the annual compliance review period. A review of the Department of Health Medical Quality Assurance License search website revealed the back-up physician's license is clear and active in the state of Florida and expires on January 31, 2021. A review of seven youth individual healthcare records (IHCR) indicated the DHA conducted sick calls when they were on-site, as well as, provided routine medical care, and periodic evaluations for youth with chronic conditions. The DHA provides all follow-up medical care when a youth is referred by nursing staff. An interview with the DHA confirmed they are on-site five days a week and they see the youth for their initial intake physical exam, periodic evaluations for chronic conditions, sick call, and refers the youth to specialists, when necessary. The DHA also confirmed they are available by telephone and answering service twenty-four hours a day, seven days a week.

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

The program has facility operating procedures (FOP) for all health-related procedures and protocols used at the facility. A review of documentation indicated the facility administrator (FA) reviewed and signed the FOPs on June 19, 2019 and the designated health authority (DHA) conducted their annual review and signed off on the FOPs on June 20, 2019. The DHA reviewed, approved, and signed off on the nursing protocols on June 28, 2019. As part of the program's nursing pre-service training plan, all new medical staff are required to review the medical FOPs and nursing protocols and sign the cover sheet indicating they have reviewed them. All seven current nurses who work at the program signed a cover letter acknowledging they have read and understood all nursing FOPs and healthcare protocols. A review of the psychiatric FOPs revealed the program's psychiatrist conducted their annual review and approval of the psychiatric FOPs on June 17, 2019 and the FA conducted their review on June 19, 2019.

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

The program has a policy and procedures in place to ensure parents/guardians are afforded the right to give or withhold consent with regards to the healthcare provided to their children while they are in the program. Seven reviewed youth individual healthcare records (IHCR) confirmed six of the youth had a signed Authorization for Evaluation and Treatment (AET), with the word 'copy' stamped or printed on the AET. One of the six records was a youth being served by the Department of Children and Families (DCF); however, the parents' rights were not terminated and there was no need for a court order authorizing medical treatment. The seventh record was a youth under the care of the DCF due to their parent/guardian's incarceration and the youths' record contained a court order authorizing all medical care; however, the youth's parent/guardian was released from incarceration and they then signed an AET since their parental rights were never terminated. All reviewed youth IHCRs were applicable for having parental notifications maintained behind the AET and all records contained parental notifications behind the AET. One of the reviewed records was a youth who had turned eighteen while at the program and they had signed an over eighteen-year-old consent form, indicating their parent/guardian could be notified of only emergent care. An interview with the health services administrator (HSA) indicated nursing staff review all arriving youth's AETs to ensure they are valid prior to arrival. If the AET is not valid, the program's medical and case management staff coordinate to ensure a valid AET is received prior to the youth's arrival. If necessary, the program would contact the assigned juvenile probation officer to obtain a new AET. The HSA also indicated a youth who is eighteen years of age upon intake or turns eighteen years of age in the program sign a release of information form indicating who may receive information about their medical care. The release of information form is filed in the youth's IHCR on top on the AET.

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 in place to address parental notification and consent for treatment. Seven youth individual healthcare records (IHCR) were reviewed for parental notifications and consent for treatment. Six of the seven records required parental notification for the entire review period; however, the seventh record was only applicable for parental notifications for a little over two months. The youth who turned eighteen while in the program signed a consent form indicating their parent/guardian could be notified when the youth required emergent care. After the youth's eighteenth birthday, all notifications were signed and provided to the youth. A review of the seven records revealed each youth's parent/guardian received parental notification for over-the-counter (OTC) medications beyond those covered by the Authorization for Evaluation and Treatment (AET). Two records were applicable for notification of a vaccination not consented for on the AET. Five of the seven records were applicable for notification when significant changes to existing medications occurred. None of the records were applicable for discontinuation of medication prescribed prior to the youth entering the Department's custody. Four of the records were applicable for changes in condition/medication for youth with chronic conditions. Four records were applicable for parental notification for hospitalization, surgeries/invasive procedures, and non-routine dental procedures. All seven youth were taken off-site for medical treatment, and each of the records contained notification to

the parent/guardian when these events occurred. Two of the seven records were applicable for off-site emergency notifications. All seven applicable records contained documentation in the nursing progress notes verbal attempts, and parental consent was received for all new medications. All seven records contained written notifications regardless if verbal consent was received. All seven records contained documentation indicating a second staff member witnessed all telephone call attempts and conversations regarding parental consent. Two of the youth were under the supervision of the Department of Children and Families (DCF); however, there was no termination of parental rights. One of the DCF youth records reflected the program did not have a good address for the youth's parent/guardian and was only able to send the notifications to DCF; however, the nursing progress notes reflected the nursing staff was in contact with the guardian by telephone, but the guardian had yet to confirm an address where notifications could be sent. Five youth were applicable for written consent for the administration of psychiatric medications and all records contained written notification with an attached Clinical Psychotropic Progress Note (CPPN), which was sent to the youth's parent/guardian. One of the youth was pregnant and required an authorization to release information about their pregnancy to their parent/guardian and there was a signed release of information found in the youth's record indicting any pregnancy information could be released to their guardian.

The health services administrator (HSA) was interviewed about parental notifications and they indicated parents/guardians are contacted by telephone to inform them of new medications, and emergent care as situations warranted. The HSA also indicated written parental notification is completed within twenty-four hours of any incident; and verbal consent from the parent/guardian is obtained as soon as possible after an order is written by the physician. During the interview, the HSA confirmed notifications to the parent/guardian occur when the youth receive OTC medications not covered by the AET, for vaccinations, significant changes or discontinuation of medications, initiating new medications, for invasive procedures, x-rays, emergent care, non-routine dental work, any off-site care, and all on-site physician encounters. The HSA further indicated when a youth is prescribed psychotropic medications, the psychiatrist attempts to obtain verbal consent from the parent/guardian with the nurse as a witness. If the psychiatrist is unable to obtain verbal consent, the nursing staff will attempt to gain verbal consent with another nurse as the witness. The program then mails out the acknowledgement of receipt and the third page of the CPPN to the parent/guardian by certified mail. The HSA also stated when medications are discontinued, or adjustments are made verbal consent is received and then the parental notifications are mailed by regular mail within twenty-four hours.

The program has a policy and procedures in place to ensure a youths' immunization history is obtained and all youth have received proper immunizations prior to their arrival. The program obtains the youth's immunization records from the youth's electronic commitment packet and from the electronic Florida Shots database. A review of seven youth IHCRs contained immunization and vaccination records confirmed by the program within thirty days of each youths' admission. Two of the applicable records revealed each youth needed one or more vaccinations. One youth did not require consent for the vaccination because they were eighteen years of age at the time of the needed vaccination and consented to the vaccination themselves. There was documentation in the second record the nursing staff verbally notified the parent/guardian(s) of the need for the vaccinations and sent out the required written consent paperwork. The parent/guardian signed the consent for the vaccinations and sent the forms back to the program. The youth has yet to receive the vaccinations as the pharmacy did not have one of the vaccinations and the program is waiting on the pharmacy to send both vaccinations the youth requires. None of the reviewed records contained a refusal for consent of immunizations for religious reasons. An interview with the program's HSA indicated the youth's parent/guardian is required to provide the program with the appropriate signed exemption form

from the Department of Health if they refuse vaccinations for religious reasons. The exemption form is then filed with the Department of Health and a copy is placed in the youth's IHCR.

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 in place for the completion of the Facility Entry Physical Health Screening (FEPHS) form on all youth on the date of their admission. A review of seven youth individual healthcare records (IHCR) found each record contained a FEPHS form completed on the date of the youth's admission. Five of the seven reviewed FEPHS forms were completed by a registered nurse (RN) and the remaining two were completed by a licensed practicing nurse (LPN).

Two of the seven youth had a change in their physical custody; therefore, an additional record was reviewed. All three applicable youth records contained a FEPHS re-screening form completed by a RN upon the youth's re-admission. All seven reviewed records contained the youth's consent for pregnancy screening and sexually transmitted diseases screening. All screening results were in the lab section of the youth's IHCR and/or on the Infectious and Communicable Disease Form. An interview with the health services administrator (HSA) indicated the nursing assessment is completed by the nursing staff following the youth's initial search by direct care staff when the youth arrive at the program. The nurse indicated the youth are normally seen by nursing staff within minutes of arrival. The HSA also indicated when a youth returns to the program after a physical custody change, the nursing staff complete a new FEPHS form and a new body chart to track any changes.

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 in place which indicate all youth will receive orientation to the program's healthcare services on the day of admission. Each of the seven reviewed youth individual healthcare records (IHCR) contained documentation indicating the youth received a healthcare orientation the same day they were admitted to the program. The program documents each youth's orientation to healthcare services on a program form entitled, Healthcare Services Orientation. There was documentation in all reviewed records showing the youth were oriented to the sick call process, access to medical care, what constitutes an emergency, the medication process and side effect monitoring, the right to refuse care and how to document it, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care staff. Each youth's orientation form indicated the youth were advised of who the designated health authority (DHA) was, as well as the who was the program's assigned psychiatrist. The program had a list of healthcare staff contacts posted on the wall in the medical clinic and it was in an area inaccessible to youth. A review of the list found the correct DHA, nursing staff, and psychiatrist were listed. All seven IHCRs also contained a completed health education record form indicating all the topics each youth had or will receive education on while at the program. Topics the youth will be educated on are prevention of accidents, alcohol/substance abuse, sexually transmitted diseases, smoking cessation, prevention of communicable diseases, cardiovascular health, physical fitness, human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) general

information, nutrition basics, dental hygiene, personal hygiene, breast self-exam, pre-natal/post-natal care, family planning, parenting skills, anxiety reduction, coping with depression, and coping with anger.

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 in place indicating after the healthcare staff reviews the youth's record and completes the screening and/or reviews the completed screenings, staff are to notify the designated health authority (DHA) telephonically or verbally for all newly admitted youth regardless of any identified medical conditions. The purpose of the notification is to provide a comprehensive overview of the youth's medical condition to the DHA and to obtain initial admission orders, initial medication orders, preliminary laboratory studies, diet orders, activity release or restrictions, and any other specific treatment orders or instructions for the youth with a health-related condition.

A review of seven youth individual healthcare records (IHCR) revealed the DHA was notified of each youth's admission to the program and the youth's medical history was shared with the doctor. There was documentation in five records of the date and time the DHA was notified. The remaining two records did not have the date and time or how the DHA was notified of the youth's admission; however, during the debriefing process, the program advised the DHA conducted the two youth's comprehensive physical assessment on the same day as the youths' admission; therefore, the DHA was on-site when the youth arrived at the program and knew about their medical histories. Two of the five applicable records contained a nursing progress note indicating the DHA was notified by telephone; and in the remaining three records, there was a progress note indicating the DHA was notified in person of the youth's admission. None of the reviewed records reflected the youth needed emergency services upon their admission. There was also documentation in five of the reviewed records the youth was referred to the doctor for their comprehensive physical assessment, while the remaining two youth did not need a referral because the DHA was there in person. An interview with the health services administrator (HSA) indicated the DHA is notified of all admissions, regardless of a youth's conditions, following the completion of admission paperwork and youth's record review. The HSA also indicated the notification occurs by the healthcare staff on the same day as the youths' arrival. The HSA indicated all youth being referred to the doctor are placed on the DHA's weekly log to ensure the youth is seen by the doctor during their next visit to the program.

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 in place indicating a Health-Related History (HRH) form will be completed within seven days of a youth's admission. A review of seven youth individual healthcare records (IHCR) revealed the program completed an HRH form on all youth upon admission to the program. All HRH forms were completed on the same day as the youth's admission. Five HRH forms were completed by a registered nurse and two were completed by a licensed practicing nurse. All HRH forms were reviewed by the designated health authority (DHA) and were all completed prior to the Comprehensive Physical Assessment (CPA). An interview with the health services administrator (HSA) confirmed the HRH forms are completed

by healthcare staff after the initial nursing assessment. The HSA further indicated a new HRH form is completed when new significant medical events occur or changes in the youth's medical status occur; however, they are updated at least annually.

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 in place to ensure each youth receives a physical health evaluation upon admission to the program. A review of seven youth individual healthcare records (IHCR) revealed each youth had a Comprehensive Physical Assessment (CPA) completed by the designated health authority (DHA) within seven days of their admission. Each CPA contained the youth's medical grade issued at admission. All seven records had the CPA completed in accordance with the Department's Rule. All records contained documentation the clinician deferred parts of the examination due to each youth having no significant past medical history in those areas, and the male portion of each examination was not applicable. All sexually active youth were referred for gynecological examinations by the DHA. All reviewed records had completed Department Problem Lists and there was documentation in each of the applicable records the youth's Problem List was updated when necessary. An interview with the health services administrator (HSA) indicated the DHA completes an initial CPA upon each youth's admission and annually thereafter.

The program has a policy and procedures in place to ensure youth receive routine healthcare screenings and evaluations upon admission to the program for latent or active tuberculosis, as well as environmental controls for the program. The program's policy follows the Centers for Disease Control and Prevention, as well as the Occupational Safety and Health Standards. A review of seven IHCRs revealed each record contained a current verified tuberculin skin test (TST) test. The tier 1 tuberculin (TB) screening portion of the Facility Entry Physical Health Screening Form (FEPHS) was completed and found in all records. All records also had the TST results documented on the Infection and Communicable Disease (ICD) form, as well as the CPA form. Two of the youth's records required an updated TST test while they were in the program, and the youth's IHCR reflect the youth received a new TST test. During the interview with the HSA, they indicated nursing staff review the Department's Juvenile Justice Information System for each youth's TST test prior to their arrival and the nursing staff complete a TB screening during the initial nursing assessment. The HSA also indicated each youth is put on a TST tracker to monitor when each youth is due for a new TST test and all TST testing results are located on the FEPHS and the ICD forms.

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 in place to ensure youth receive sexually transmitted disease/infection screening, evaluations and testing. A review of seven youth individual healthcare records (IHCR) revealed all youth were screened by nursing staff upon admission for sexually transmitted infections (STI). The designated health authority (DHA) ordered STI testing for all seven youth based on the youth's answers to the STI screening and the DHA's orders. All records indicated STI testing was preformed and the results of the testing was documented on the Infectious and Communicable Disease (ICD) form, and the lab results were found in the lab

section of the youth's IHCR. All records also contained the order for testing, which was found in the DHA and nursing progress notes. None of the reviewed records were for youth who were out of the Department's custody for more than thirty days and did not require a re-screening for STIs. An interview with the health services administrator (HSA) confirmed youth are interviewed during their initial nursing assessment to obtain their sexual history and the DHA has a standing admission order for all youth to be screened for STIs regardless of their risk. The HSA confirmed all STI screening results are recorded on the ICD form and the lab results are filed in the laboratory section of each youth's IHCR. The HSA also indicated if a youth is out of the Department's custody for over thirty days they would have the doctor order new STI testing and document the results in the youth's IHCR.

The program has a policy and procedures in place to ensure all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, and referred for medical treatment. The program uses Metro Wellness and Community Centers to conduct pre- and post-HIV education, as well as conduct a rapid HIV test. The program's practice is to have an individual certified by the Florida Department of Health-Division of Disease Control and Health Protection from Metro Wellness come to the program to conduct HIV prevention counseling, testing and linkage to services. The program supplied the annual compliance review team with the Metro Wellness individuals 501 HIV/AIDS certification by the Florida Department of Health, which was updated June 20, 2019. A review of seven youth IHCR revealed all youth were offered HIV testing, counseling, and received general education about the disease. Six of the seven youth records revealed each youth consented to HIV testing and the consent was documented on the program's HIV consent form. All applicable youth received pre- and post-testing counseling from the Metro Wellness certified HIV counselor and the testing was documented on each youth's IHCR. All applicable records contained a sealed envelope, which contained the youth's HIV testing results, and the envelope was marked confidential. A review of the program's internal medical alerts and the Department's Juvenile Justice Information System (JJIS) alerts revealed there were no alerts related to a youth's HIV status.

An interview with the HSA indicated each youth is screened HIV risk during the initial nursing assessment and are asked if they want to be tested. The youth signs a Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent Form and marks if they consent or refuse testing. The HSA indicated each youth is put on the program's HIV log which identifies the youth who have requested testing and the ones who declined testing; then when the HIV counselor comes out to the program, they provide HIV education and testing to the youth on the log who consented to testing. The HSA also indicated youth can ask for an HIV test any time they want to be tested, even if they previously refused testing. The regional HSA indicated if a youth first refused testing but decided to get testing they would have to sign a new consent form, receive the pre-and post-testing, and be tested. The HSA confirmed the program's seals all HIV test results in an envelope, mark it confidential and file it in the lab section of the IHCR and the results are given to the youth upon their release. All seven interviewed youth indicated they could request an HIV test if they wanted one.

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

The program has a policy and procedures to ensure a system is in place to response to the complaints of youth illness or injury of a non-emergent nature. The policy indicates sick call care, including dental complaints, shall be available to all youth. Sick call care shall be provided by licensed health care professionals, pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). The program has postings of the sick call hours in each of the three dormitories, in administration, and on the medical clinic door. The program also has sick call forms available in the cafeteria, as well as with the shift supervisor. The locked sick call box is in the cafeteria and is checked several times a day by nursing staff. The program completes sick call daily from 11:00 a.m. to 1:00 p.m. and has nursing staff on-site twenty-four hours a day, seven days a week. There is never an instance where a sick call or medication is given to a youth by a non-licensed staff. Sick call is always conducted by a nurse or DHA.

A review of seven youth individual healthcare records (IHCR) revealed five youth submitted one or more sick call requests, for a total of thirty-one sick calls. Three of the youth presented with similar sick call complaints three or more times within a two-week period, for back pain and tooth pain and all three youth were referred to the DHA for follow-up. All thirty-one sick call requests forms were filed in the progress note section of each youth's IHCR in reverse chronological order. There were no sick call complaints of any severe pain with which nursing staff were unfamiliar. All sick call forms were documented in accordance with the Department's Rule and contained the youth's vital signs, treatment, education, and any follow-up plans. All sick calls were documented on the youths' sick call index in their IHCR and on the program's sick call referral log. During the annual compliance review, a sick call was observed after the youth and nurse granted permission for the reviewer to be present. The youth was escorted to the medical clinic by a direct care staff, who stood in the hallway with the clinic door cracked for security reasons; however, the youth's confidentiality was maintained during the entire sick call. The nursing staff identified themselves to the youth, the youth sat in a chair and reviewed the sick call request form with the nurse. The nursing staff discussed the youth's symptoms and took the youth's vital signs. The nursing staff and the youth discussed the fact the youth had pro re nata (PRN) medication she was prescribed. The youth then received medication as prescribed. The youth reviewed and signed the sick call form prior to exiting the medical clinic.

Seven staff were interviewed and they all indicated nursing staff conduct sick call and responds to all sick calls. Seven youth were interviewed and they all indicated they could see the nurse within one day of putting in a sick call. An interview with the health services administrator (HSA) indicated the youth are oriented to the sick call process during the admission process and the youth can submit a sick call any time by placing a completed form in the sick call box. The HSA indicated the box is monitored by the nurses at regular intervals throughout the day, at least every two hours, and then the nurses prioritize the calls during the scheduled sick call time. The HSA indicated the youth are assessed/seen within twenty-four hours of placing their sick call. The HSA indicated sick calls are conducted by licensed health care staff; however, if a sick call is completed by the licensed practicing nurse (LPN) they consult with a registered nurse (RN) and then the RN will sign off on the sick call. The HSA confirmed sick calls are conducted in the

medical clinic and youth are seen daily based on the nature of the compliant and symptoms. During the interview the HSA confirmed if a youth complained of the same issue three times within a fourteen-day period they are referred to the DHA and are placed on the DHAs clinic log.

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 comprehensive process for the provision of episodic, and first aid care. The program has nursing staff on-site twenty-four hours a day, seven days a week, and there was no evidence of non-healthcare staff providing first aid/or episodic care to the youth. A review of seven youth individual healthcare records (IHCR) confirmed all were applicable for episodic care, first aid, and/or emergency care. There were seventy-six instances of episodic care in the reviewed records. Nursing staff documented each event in the nursing chronological progress notes and labelled it as an episodic incident. Each episodic incident was documented in problem-oriented narrative charting indicating the subjective, objective, assessment, and plan (SOAP) format. All instances of episodic care were listed on the program's episodic care log. In sixteen out of the seventy-six instances of episodic care, the licensed practicing nurse provided care to the youth. In four of those sixteen instances, there was a lack of documentation to support the care provided by the LPN was signed off on by a registered nurse (RN). There was documentation to support the care was discussed with the RN, but the RN never signed off on the episodic care forms found in the IHCRs.

The program has a policy and procedures for the provision of emergency medical care, including emergency dental treatment. The DHA is available by telephone twenty-four hours a day, seven days a week for consultation. Postings were found throughout the facility informing staff of their right and responsibility to call 9-1-1. A review of fourteen non-healthcare staff training records contained documentation of current first aid, epinephrine autoinjector, basic cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) certifications. All seven nursing staff members maintain current first aid, CPR, and AED certifications. The program had listings of emergency telephone numbers to include the Poison Control Center number in the medical clinic and master control; and they were inaccessible to the youth. Interviews with seven staff indicated six staff knew they were personally allowed to call 9-1-1 if a youth or staff has a medical emergency; and the seventh staff indicated they could not call 9-1-1 because they do not have access to telephones to make the call. Seven youth were interviewed, and six youth indicated they could see a dentist if they had tooth pain, while one indicated they could not. All seven interviewed youth indicated they could see a doctor if they needed to.

The program has seven first aid kits and they are in master control. The program has two suicide response kits and one is in master control, and the other is in the medical clinic. Documentation supported the nursing staff conducts weekly reviews of the first aid kits and suicide response kits. During the annual compliance review, a review of five first aid kits, which included two first aid kits used for transport, were observed to be fully stocked with all content approved by the DHA. The program has one AED which is located within master control. The AED procedures are located within the AED box and in the medical clinic. The AED battery expires in September 2023 and was last changed on September 9, 2019. The program has a back-up battery which indicates it needs to be installed prior to March 2025. The AED pads expire in February 2020 and were last changed on October 19, 2017. Reviewed documentation confirmed the nursing staff conducted monthly testing of the AED for the entire annual compliance review period. The program is required to conduct monthly medical drills on all three

shifts with CPR/AED being practiced at least quarterly. The review period allowed the team to review three quarters of medical drills and there were medical drills conducted on all shifts monthly, with one of the monthly drills requiring the demonstration of CPR and the use of the AED.

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 in place outlining the programs procedures for off-site care and referrals. Seven youth individual healthcare records (IHCR) were reviewed and six were applicable for off-site care. There were twenty-seven off-site care appointments reviewed in the six applicable records. All six records were applicable for parental notification and all records contained parental notifications. All applicable records had the Departments' Summary of Off-Site Care form used and were filed in each youth's IHCR with any discharge/pertinent information. All off-site care forms were reviewed and signed by the designated health authority (DHA). Three of the six applicable records required follow-up testing, referrals, or appointments and there was documentation in each applicable record the youth received the necessary follow-up care.

An interview with the health services administrator (HSA) indicated the program tracks all youth's off-site first aid or emergency care by documenting the incidents on the program's episodic log, and daily shift log. The HSA also indicated the nursing staff reviews all hospital and/or doctor's orders upon the youth's return to the facility to ensure all orders are followed and contacts the DHA for a review of the information and any recommendations. The HSA further indicated the nursing staff ensured the DHA reviews all off-site forms/orders on their next visit by putting the information in the DHAs review folder. The DHA confirmed the nursing staff provides them with all off-site care forms for review by placing them in a review folder, which they review the next time they are on-site. During the interview with the has, they also indicated the nursing staff use the internal nursing outlook calendar to track follow-up testing, referrals and appointments for the youth, as well as, by communicating during shift change.

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 in place for youth with chronic medical condition(s), which indicates youth shall have treatment plans/physical progress notes which specify a youth's course of therapy, identifies the role of qualified health professionals in carrying it out, and is updated as needed. The policy further indicates youth with a chronic condition, communicable disease, receiving prescription medications including psychotropic medications, or are being treated for tuberculosis shall receive a periodic evaluation from the physician every sixty days.

A review of seven youth individual healthcare records (IHCR) revealed all youth had one or more chronic medical conditions identified and required placement on the program's chronic condition list. One youth was placed on the chronic conditions for having a communicable disease. Six youth were on the list for taking prescribed medications on an on-going basis.

Three youth were on the list for physical health conditions including a body mass index of greater than thirty. All seven youth were classified with a medical grade greater than two and were on the list. One youth was identified as being pregnant and placed on the chronic list. A review of the program's chronic condition list revealed all youth were appropriately placed on the list and their corresponding medical conditions and/or medication regiments were properly listed. All youth identified with a chronic medical condition were seen by the DHA every sixty days for a periodic evaluation. Three youth who were on the chronic conditions list due to being on psychotropic medications and each received monthly medication monitoring by the psychiatrist. All documentation for the periodic evaluations and medication monitoring evaluations were found in each youth's IHCR. All reviewed youth records contained specialized treatment plans for the youth based on their chronic condition. None of the youth were applicable for anti-tuberculosis medications. The youth who was identified as pregnant had evaluations conducted every two to four weeks for the first eight months of her pregnancy and then every two weeks during her eighth month. The youth received weekly evaluations during her last month of pregnancy. Four of the seven reviewed records reflected a periodic evaluation or a medication management evaluation was conducted prior to the renewal of any prescription medication. All treatment orders were written clearly and were distinguishable for clinical staff to interpret. None of the periodic evaluations were conducted off-site. All reviewed records revealed there were no lapses in care or missing periodic evaluations. A review of the applicable youth IHCRs revealed all youth's problem list accurately reflected each youth's physical health, dental health and mental health.

An interview with the DHA revealed all youth with a chronic condition are evaluated every two months and all youth with chronic conditions are placed on the program periodic evaluation tracker. An interview with the health services administrator confirmed youth who are identified with a chronic condition are placed on the programs medical tracker for monitoring and tracking of periodic evaluation due dates.

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 in place to ensure youth receive all prescription medication(s) as prescribed by a physician. The policy indicates medical staff shall verify any medications arriving with newly admitted youth. The program's policy also indicates only medications from a licensed pharmacy, with a current, patient-specific label intact on the original medication container may be accepted into the facility. The policy further indicated verification of the actual medication contents is not required if the youth has been transferred directly from the Department and the medications have been under the Department's controls the entire time.
A review of seven youth individual healthcare records (IHCR) revealed five youth entered the program with currently prescribed medication. The five applicable youth entered the program with medications from a Department detention center and verification was noted on the Department form entitled, Medication Receipt, Transfer, and Disposition. Each youth's nursing progress note indicated staff verified the youth's medication with the parent/guardian upon the youth's admission. All applicable records reflected the designated health authority (DHA) was notified when the youth entered the facility with prescribed medications. All youth records reflected the DHA advised the program to continue all medications until the youth were seen in person for their initial medical evaluation. Two of the five youth entered the facility with psychotropic medications, and the program's assigned psychiatrist was also notified of the

youth's admission and the psychotropic medications they were taking. Each youth's nursing progress note indicated the psychiatrist continued all medications until the youth were seen in person for their initial psychiatric evaluation. An interview with the health services administrator (HSA) indicated the program has twenty-four hour nursing and only licensed medical staff verify the youth's medications with the records sent from the Department detention center, and with the parent/guardian during the initial nursing assessment. The program did not have any instances of restricted housing; however, the program's policy indicates youth in restricted housing will be given their medications as ordered by the physician.

Four of the seven reviewed records reflected the youth received over-the-counter (OTC) medications not listed on the AET form and they were administered in accordance with the approved nursing protocols. None of the youth's parents/guardians prohibited the administration of OTC medications. All seven reviewed youth IHCRs contained one or more MAR forms. Five of the seven records were for youth who arrived at the program on medication and all applicable records contained an initial MAR which matched the medication the youth arrived with. All MAR forms contained the youth's name, Department identification number, date of birth, allergies, precautions, medical grade, side effects, and medical alerts. A photograph of each youth is maintained in the current medication administration book, along with the current month's MAR. Each MAR indicated the youth received medication as ordered and the MARs clearly indicated when medication started and stopped. Each time a medication was administered the staff initialed the medication entry. A review of the MARs indicated nursing staff documented weekly side effect monitoring for all medications administered. There were no lapses or errors in medication administration in the any of the reviewed youth records. All refusals were marked with the letter 'R' on the MARs and had a corresponding signed refusal form in the nursing progress notes. An interview with the HSA indicated the program uses pre-printed pharmacy MARs which include all applicable Department requirements.

Observations of the medical clinic indicated the office was neat, clean, and organized and locked upon entry. The medical cart where all medications were stored was neat, clean, organized, and locked. The program stores oral medication separately than injectable and topical medications. The program stores narcotics and other controlled medications in a lockable drawer within the locked medical cart. All other medications are stored in the medication cart, which is secured, locked and inaccessible to the youth. The program has a process in place for the destruction of expired and/or discontinued medications. Unused non-controlled medications which are within the expiration date are returned to First Choice Pharmacy by giving the medications to the pharmacy consultant who comes to the program monthly and the program is given credit for the unused medications. The program maintains documentation to support the medications were returned to the pharmacy. If the unused non-controlled medications are expired the program destroys the medications by using a medication jar called RXDestroyer. Two nurses verify the medication and then places the unused medication in the RXDestroyer jar and when the jar is filled it is disposed of in the trash. All unused controlled medications are destroyed with the pharmacist and two nurses. The destruction of all medications is documented on the program's disposal of medication logs. A review of the logs indicated all medications were destroyed in compliance with the program's policy and procedures.

An annual compliance review team member was able to observe a noon medication pass. Each youth was brought to the medical clinic door by direct care staff. When each youth came to the door, the nurse verified the youth's name, the medication, the route, the dosage and time of dosage. The nurse also asked each youth about their allergies and side effects of the medications they were receiving. An interview with seven youth indicated they all knew the

nurse provides medications to the youth. Two of the youth indicated they did not take medication but knew the nurse provided medications to the youth; the two youth were not able to articulate the program's medication pass process. The remaining five interviewed youth were able to articulate the program's medication pass process. An interview with seven staff indicated the youth receive their medications from nursing staff.

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

The program has a policy and procedures in place for the storage of medications, and sharps. The program's policy indicates the program shall ensure all chemical products, drug and medicines, and medical, dental instruments assigned to the medical department are securely stored, regularly inventories, disposed of and properly maintained in accordance with federal and state laws.

Observations of medications indicated they were stored within the program's medical clinic. The youth's medications and over-the-counter (OTC) medications are in a locked medical cart maintained in the clinic. When observed, the cart was locked and has separate storage areas for different forms of medications. The cart has an area where youth's medications are stored and has an additional lockable drawer, with a different key, which is used for controlled substances. The program contracts with First Choice Pharmacy, who is responsible for filling medication requests. The program also has a contract with a pharmacist who comes on-site monthly to retrieve medications for return, consultation and to aid in the destruction of medications. A review of the Department of Health Medical Quality Assurance License search website revealed the pharmacist license is clear and active and expires on December 31, 2020. The program's medical department maintains a copy of the pharmacist's license in the medical clinic.

An interview with the health services administrator (HSA) indicated all medications are inventoried daily with a perpetual count. The program also conducts weekly counts of medications and the HSA confirmed medications are stored within the medical clinic in locked cabinets and/or the locked medical cart. The HSA also confirmed class two medications are destroyed on-site with the pharmacist, a nurse, and the facility administrator/designee and all other medications are returned to the pharmacy. During the interview the HSA also confirmed all controlled medications are stored in a secure storage box within the secure medication cart. Observations confirmed all medication and sharps were securely stored in locked cabinets in the medical clinic. Syringes and sharps were counted using a perpetual inventory. The inventories are verified on a weekly basis, and the reviewer was able to observe the weekly counts were conducted for the entire review period. Opened OTC medications were inventoried using a perpetual inventory and verified weekly, and the reviewer was provided with documentation to support the nursing staff conducted the weekly counts for the entire review period. The program also conducts shift-to-shift counts of controlled medications. The program maintains all controlled medication counts within the youth's individual healthcare record or in the current monthly medication administration record book. The program has a policy and procedures for detecting and responding to inventory discrepancies. A review of the Department's Medication Administration Records (MAR) and documentation confirm the program maintained perpetual daily inventories for all prescription medications. During the review, an inventory of three sharps (suture removal kits, large nail clippers, and 1ml T.B.

Syringes), three controlled medications, three prescription medications and three OTC medications were conducted by a review team member and all counts were found to be accurate.

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

The program has an exposure control plan and a policy and procedures in place for the control of infectious and communicable diseases. A review of documentation indicated the facility administrator (FA) reviewed and signed the plan on December 26, 2018 and the designated health authority (DHA) reviewed it on July 10, 2018. There have been no updates to the plan since approved by the DHA. An interview with the facility administrator (FA) indicated the exposure control and infection control plan is located with the facility operating procedures binder maintained in master control and a copy is maintained in the medical clinic.

The programs' infection control procedures included prevention, containment, treatment, and reporting requirements, as required by the Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control and Prevention (CDC) guidelines. The infection control procedures address all required types and categories of diseases outlined in the Department's Rule. There were no instances in which the local county health department, CDC, or the Central Communications Center (CCC) required notification of an infectious disease. The program's exposure control plan includes risk assessment and methods of compliance and contains all requirements of the OSHA federal regulations. The policy also included a comprehensive process for needle stick post-exposure evaluations. The program has not had any youth or employees who have experienced a facility/occupational exposure during the annual compliance review period. There were no instances involving quarantining or hospitalization of at least ten percent of the program's total population or staff during the annual compliance review period. A review of fourteen staff training records indicated all staff received annual training in infection control and site-specific exposure control plan. All staff are offered Hepatitis B immunizations at the cost of the program. Seven reviewed youth individual healthcare records contained evidence of training in infection control, hand washing techniques, universal precautions, prevention of communicable diseases, and vaccinations within seven days of their admission.

An interview with the health services administrator (HSA) confirmed the program has an exposure control plan and infection control policy, and training is conducted twice a year by a licensed nurse at the facility. The HSA also indicated infections control training is taught to newly hired staff during their pre-service training by a corporate trainer. During the interview, the HSA also indicated youth receive infection control education upon admission and during monthly health education groups.

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

The program has a policy and procedures in place which indicates the program shall provide gender-sensitive and trauma informed primary services, gynecological care, and obstetrical services to the youth at the program. A review of seven youth individual healthcare records (IHCR) revealed one youth was currently pregnant and was in the last month of her pregnancy. The program did not have any other youth in the facility during the annual compliance review period who were pregnant. A review of the one applicable record revealed the program provided the youth with prenatal care immediately upon their admission and the care has continued throughout the youth's stay in the program. The youth's IHCR revealed the youth was placed on the program's internal alert system, as well as in the Department's Juvenile Justice Information System (JJIS) for being pregnant, having double portions, and extra snacks. The youth's IHCR contained information showing the youth was educated on the following topics: alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, shaken baby syndrome, anger management, time management, and parenting skills. During an interview with the health services administrator (HSA) they confirmed the youth has or will receive all the above listed trainings.

The youth's IHCR also revealed the youth's birth plan, and post-birth plan. The record also confirmed the youth received education and pregnancy care from the designated health authority (DHA), Exodus Obstetrics and Gynecology (OBGYN), and Nurse Family Partnership. The youth's medical record also confirmed the youth consented to Human Immunodeficiency Virus (HIV) antibody testing and signed the appropriate consent form. The results were filed in the lab section of the youth's IHCR, in a sealed envelope marked confidential. The youth was seen by the DHA, and OBGYN at regular intervals and all complaints by the youth resulting from the pregnancy were immediately addressed by either party. The reviewed IHCR revealed the DHA followed-up with the youth after every off-site visit to the OBGYN. The record also revealed the youth received routine monitoring for nutritional and weigh status since entering the program. A review of seven pre-service and seven in-service training records revealed all non-healthcare staff received training on girls' health and pregnancy. The program nursing staff also conducted a girl's health and pregnancy complication training at the programs all staff meeting in June 2019.

An interview with the health services administrator confirmed youth who are pregnant receive periodic evaluations, pre/post-natal care, HIV testing, on-going health education, daily monitoring, special diets, education on family planning and vaccinations if necessary. The HSA further advised youth who are pregnant receive daily observations and monitoring for danger signs related to pregnancy and these observations are documented in the youth's medication record. Seven youth were interviewed, and all the youth indicated they had not received pre-natal, obstetrical, or gynecological services while in the program.

Standard 5: Safety and Security

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

The program has a policy and procedures regarding youth supervision addressing active supervision requirements. The program's staff to youth ratio for day time activities is one to six and night time is one to eight. The staff and youth were observed every day of the annual compliance review during school/education, recreation, meals, breaks, and line movement regarding supervision. The staff interacted positively with the youth throughout the days of the review and when staff were asked the number of youth they were supervising, they could state the number without conducting a count. The staff were observed monitoring youth behavior and implementing the behavior management system. The staff were positioned adequately to supervise youth and maintaining safety and security. The monitor conducted a review of seven ten-minute check sheets which included youth being in their rooms sleeping or during day time activities, like hygiene. The staff conducted a total of six checks at more than the required ten-minute intervals. The program has a full schedule of activities, which is posted throughout the building. A review of incidents reported to the Central Communications Center (CCC) for the last six months revealed nineteen allegations of improper supervision. At the time of this review, five of the nineteen allegations were substantiated; three of which were substantiated by the provider, one was unsubstantiated, one unfounded and twelve are still open and under investigation.

Seven staff were asked if they cannot reconcile the youth count what is the process. All staff indicated they would count again, if unable to reconcile master control, stop all movement and have the whole program conduct a count.

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 regarding the behavior management system (BMS)/positive performance system (PPS). Procedures outline positive and negative consequences for behaviors, maintaining order and security, promoting and protecting youth rights, constructive disciplinary actions/non-punitive measures, opportunities for positive reinforcement, recognition of accomplishments and positive behaviors at a four to one ratio, promoting socially acceptable means for youth to meet needs, process for explaining to youth the reason for any sanction imposed, youth opportunity to explain her behavior, and for staff and youth to discuss impact of behavior on others. The BMS also included reasonable reparations for harm caused to others, discussion of alternate behaviors, promotion of positive dialogue and

peaceful conflict resolution, separation of youth from population is minimized, coordination with any individual behavior plan, and consistent implementation and treatment through oversight. Seven youth case management records were reviewed and indicated the BMS is included in the youth handbook and given to youth at the time of admission. All seven staff interviewed regarding the BMS indicated it is a point system/level system and works on rewards and consequences on a four to one ratio. One also stated it is in the youth handbook which is provided during the orientation process. The staff also said youth receive incentives like boutique, outings, lots of snacks (ice cream, cheeseburgers, and Oreo cookies) and able to hang out with favorite staff in administration. Youth are also allowed to do a creative project, have game room access, have later bed time, play board games, facials/spa, extra time to watch television, and participate in movie nights.

Seven youth were interviewed regarding consequences and rewards used in the program. All indicated a consequence can be a level freeze, five stated they get an incentive freeze, as well as two stating write-ups/special treatment team will be conducted. One said youth are placed in room until they calm down, if caught fighting. Two youth said watching television/movies and parties is used as incentive; seven stated fast food/snacks are also utilized. Four of the youth indicated incentives can be boutique access and games, and one stated outings and facials. Five said participating in creative projects is also a reward. One youth indicated the BMS used is very good, three saying it is fair and another three rating it as good. The seven youth were asked to explain the difference between each level and how youth move from level to level in the BMS. All seven youth indicated the BMS has levels with certain time frames in between moving up to the next level. Six stated they are on foundation level for twelve days, radiance for thirty days, harmony sixty days, and ninety days for both elegance and grace. The youth also mentioned each level a youth accomplishes she can get more perks. Youth are required to get signatures and complete assignments and hours to move up to the next level.

The facility administrator was interviewed regarding the BMS being utilized in the program and was asked to explain the system. She indicated the program utilizes a BMS compiled of a series of levels. The youth complete each level by earning daily points to receive positive days in the program. Earning positive days allows youth to also participate in nightly incentives. If a youth has a behavioral infraction she can lose points. After the loss of so many points she will not earn enough points to make her positive day which hinders her progression in the level system. Additionally, youth can earn a special treatment team referral for more serious behavioral violations, often these referrals result in “level freeze days” which also extends the youth’s progression in the program. She was asked how the program ensures the rewards outnumber the consequences four to one and how are consequences monitored. She indicated the incentives are provided nightly, weekly, and monthly. Youth can utilize their earned points to buy items in the program’s boutique. The program utilizes a daily tracker to manage each youth’s progress. Youth are referred to a special treatment team review; the appropriate consequence is provided, and youth understand the expectations to get back on a positive track. The daily tracker also reflects if the youth is on level freeze and she can monitor her progress as she earns positive days.

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 addressing staff providing feedback to youth regarding the implementation of the behavior management system (BMS), including any imposed sanction, prior to the end of the staff's shift. The system describes the process for the youth to receive the opportunity to explain the behavior, discuss the impact of the behavior on others, reasonable reparations for harm caused to others, and alternative acceptable behaviors. The BMS does not include an increase in length of stay, denying youth basic rights or services, promoting group punishment, punishment of youth by other youth, disciplinary confinement, wherein a youth is isolated in a locked room as discipline for misbehavior/room restriction. Six staff position descriptions were reviewed regarding the implementation of the program's BMS; all contained the job function. Seven pre-service and seven in-service training records were reviewed; all staff received training in the implementation of the program's BMS. Seven staff were interviewed and asked how youth are informed of the consequences and how they can explain their behaviors. Five of seven stated during special treatment team everyone is present to discuss behavior violations with the youth; the youth can discuss actions and advocate for them self during this time. One staff stated each youth can explain their behavior and actions in written format and verbally with staff. Another said youth have the option to review their write-ups, they can discuss what was written up regarding their behavior with direct care staff and case management, and sign to acknowledge the review and accept what was discussed. The seven staff were asked to explain how supervisors provide feedback to staff regarding the implementation of the BMS; four stated during one-on-one meetings with staff, one said during morning management meetings (discussion trickles down to floor staff) and is communicated through email, and two indicated they were unaware of this happening and had never experienced feedback from supervisors.

The facility administrator was interviewed regarding how the BMS is monitored to ensure it is administered fairly and consistently among all staff. She stated the staff are evaluated from commendable to unacceptable regarding the participation in the maintenance of the therapeutic milieu of the living unit, enforcement of the level system or other methods of the BMS.

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

The program had forty-six cameras, one of which was not working during the annual compliance review week. The camera had been recently pulled down from the ceiling by a disruptive youth.

The camera recordings are stored for up to thirty days. The program requires staff to complete six-minute checks, instead of every ten minutes, and the program was on two twelve-hour shifts, instead of three eight-hour shifts, during the annual compliance review period.

A total of seven ten-minute check sheets with correlating video footage were reviewed, with examples taken from each module, as well as both shifts. A review of video footage revealed a total of seventeen ten-minute checks, which were documented on the ten-minute check sheet, were not completed. Additionally, footage showed six checks were conducted over the required ten-minute interval; one check had thirty-nine minutes between checks. When the program was informed of the discrepancies, the incident was reported to the Central Communications Center (CCC).

Seven staff were interviewed regarding how often room checks are conducted and what process is there for documenting those checks. All seven indicated checks are conducted every six minutes; one also mentioned when a youth is on precautionary observation status, then it would be every five minutes.

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

The program has a policy and procedures to address the youth's census, counts, and tracking. Procedures indicated there must be a minimum of one female staff assigned on each shift, youth care workers are required to radio master control before every movement, and staff shall always know number the of youth being supervised. Master control tracks the program's census. A review of logbooks indicated the program conducts counts at the beginning and end of each shift, as well as at a minimum of every hour, including after outdoor activity, and youth temporarily off campus. Observations made by the annual compliance review team members validated the programs practice.

Seven staff were interviewed and asked how and when youth counts are conducted and what happens when there is a discrepancy, including emergency counts. One of the staff members stated every hour a count is conducted and if a count is wrong youth are to line up in front of their door and an emergency count is conducted until it is cleared. One said counts are done at five to six-minute intervals when youth are sleeping, four staff indicated every hour counts are done, and if not cleared or there is a discrepancy, an emergency head count is completed by master control. If the count still is not cleared, the supervisor conducts the count until all is

cleared by master control. One staff indicated floor staff during each movement conduct counts and master control does one every two hours.

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

The program has a master control logbook utilized during the hours of 7:00 a.m. to 7:00 p.m. which provides more detailed information, including documenting formal and informal population counts at the beginning and end of the shifts, including but not limited to other counts conducted during the shift, security checks, youth releases, incidents, searches, codes, transports, heat index, check of cameras, medication pass, youth movement, controlled observation, close supervision, as well as law enforcement presence. The program also has a shift logbook which is used twenty-four hours a day, seven days a week, summarizing the events, incidents, and activities documented in the master control logbook. The staff are verbally briefed at the beginning of their shift about the contents of the shift report/shift logbook. The staff sign the shift logbook to acknowledge their review of the contents. The logbooks are maintained in master control for a minimum of forty-eight hours. A review of the logbooks indicated the logbooks were bound with numbered pages, entries were made in ink with no erasures or white-outs, no entries were removed, errors were struck through with a single line, dated, and initialed by the staff correcting the error. The entries included the date and time of the event, with the name of the staff and youth involved, a brief description of the event, and the name of the staff making the entry. A sample of eight Central Communications Center (CCC) incidents were reviewed; all were documented in the logbook.

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 which include the control and use of keys, key assignment and restricted usage, inventory and tracking of keys, secure storage of keys not in use, procedures addressing missing or lost keys, and reporting and replacement of damaged keys.

The annual compliance review team observed the distribution of assigned and personal keys, as well as the collection of personal keys conducted by a master control operator/designee. The key inventory corresponded to the keys in use. The program has a key storage area for personal keys located in the sub control room by the lobby. The key box is secured and cannot be accessed when locked. The key box contained visitor passes which are provided to visitors in exchange for their personal keys, when entering the program. The box also contained hooks with staff name tags for their personal keys. The two key boxes in master control were observed

to contain restricted and active keys; both were locked while not in use. Neither could be accessed while locked. The program did not have any key control issues in the last six months requiring a call to the Central Communications Center (CCC). A review of six key rings assigned to the facility administrator, the director of case management, the health services administrator, and three youth care workers indicated all had their assigned keys, matching the key inventory. The interview conducted with the master control operator regarding the process for restricted key usage, as well as the method for the daily tracking and reconciliation of keys indicated restricted keys are only assigned to certain staff members on a daily basis. He stated an inventory of all program keys is conducted at the beginning and end of each shift and the findings are documented in the logbook.

Seven staff were interviewed and asked to explain the program's key control process including how keys are assigned, the process for missing or lost keys, damaged keys, and restricted keys. All stated, staff keys are given to master control upon entry, daily tracking of keys is done with a key log and master control is notified when keys go missing. Six stated program keys are assigned to staff, five said personal keys are securely stored and four mentioned the facility is searched for missing keys, and damaged keys are replaced. Two said youth are searched for missing keys and one stated visitor personal keys are given to master control upon entry and the CCC is called if keys go missing. Staff also indicated the facility is locked down when keys are missing, all locks must be changed if lost keys are not found within forty-eight hours, restricted keys are assigned to certain staff, everything stops when keys are missing, and no one enters or exits the program. One staff indicated never having had any issues regarding missing or damaged keys.

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 address the prevention and entry of contraband into the program, including definition of items/materials considered contraband, as well as exceptions, the provision of a list of contraband items to youth, informing them of the consequences when found with contraband, searches of the physical plant, facility grounds, youth, and incoming/outgoing mail. The procedures also detail documenting incidents, staff training, actions taken when contraband is found (staff found in possession face disciplinary action up to dismissal) and involvement of law enforcement.

The program documents confiscation of contraband and the disposal of contraband on the room search log, and youth search and full body visual search form, as well as each youth case record. The program did not have any illegal contraband in the last six months. The program's procedures indicate room searches are to be conducted, at a minimum, once a week. A review of room searches in the last six months indicated the program did not conduct room searches for three of those weeks, as well as not having fully completing three youth searches and full body visual searches in the same time frame.

The facility administrator (FA) interview indicated the control of contraband and unauthorized items is imperative for the orderly operation of the program, and for the safety and wellbeing of the population, staff, and the public. It is the duty of every staff to assist in the prevention, detection, and removal of contraband/unauthorized items from within the facility boundaries. When conducting any type of search, staff shall ensure search procedures reflect trauma-informed practices. Unannounced, random youth room searches shall be conducted. Searches of common areas shall be conducted before and after the use by youth. All searches, as well as the findings and disposition of contraband/unauthorized items, shall be documented. The FA shall determine the method of disposition of contraband and unauthorized items which are not illegal. Such contraband and unauthorized items may be discarded, returned to the original owner, mailed to the youth's home or stored and returned to the youth upon his or her release. Law enforcement shall be contacted if any found item would be considered illegal, as defined in state law, or if there is evidence of unlawful activity.

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 annual compliance review team observed youth searches being conducted after groups, before and after transports/education, and returning from off-campus activity during the review week. The female staff conducting the searches spoke to the youth when completing the task and the youth were treated with dignity and respect during the process. The searches were conducted according to the Protective Action Response (PAR) training manual.
Seven staff interviewed were asked regarding when and how youth searches are conducted; all seven indicated searches are completed during every movement. Also, one specified youth are searched after visitation, transports, and family day, three said searches must be done by a female staff, two said before every movement and one indicated before and after every movement, breakfast, lunch, dinner, education, transport, and outside recreation.

Seven youth were interviewed regarding when searches are conducted. All indicated when movement occurs, one specifying when returning from off campus, another indicated after outdoor activities, one stated when items are missing, and another said after visitation. One youth indicated after meals and another said after work detail.

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

The program has two vehicles used for youth transportation. Both are new vehicles and received an annual inspection on September 16, 2019. No additional maintenance or repairs were recommended. During the annual compliance review, observations were made of both vehicles. The vehicles were secured and contained the appropriate number of seat belts, a safety screen, fire extinguisher, and the door to the passenger area could not be opened from within. Each vehicle's key chain included a window punch and seat belt cutter. Both vehicles had an approved first aid kit, which is maintained in master control, until the vehicle is used. A random check of vehicles was conducted throughout the days of the review; all were found to be locked while not in use.

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

The program has a policy and procedures addressing youth transportation and driver eligibility, including assignment of a phone/radio to transport, one to five staff to youth ratio with a minimum of two staff per transport, staff shall not leave youth unsupervised in a vehicle and youth are not allowed to drive program vehicles. Two transports were observed. Both times, there was one male and one female staff accompanying one female youth. The vehicle had a safety screen separating the front seat from the passenger compartment, all individuals were wearing seat belts and the youth was not attached to the vehicle beyond the seat belt. All transporters had current valid driver licenses.

Seven staff were interviewed and asked what type of communication devices are provided to them during transports and if they can use their own vehicles. One staff indicated they had no experience with transporting youth but has seen staff receive a two-way radio. The other six staff stated they are provided a cell phone and three also said a two-way radio. All seven said they are not allowed to use their own vehicle for youth transport.

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

The program has a policy and procedures outlining the inspection process to include who is responsible for conducting the weekly security audits and safety inspections, the development and implementation of corrective actions warranted as a result of safety and security deficiencies found during any internal/external review/audit/inspection, as well as an internal system to verify the deficiencies are corrected and existing systems are improved or new systems are instituted as needed to maintain compliance, meeting the requirements of the Department's Rule.

The last six months of weekly safety and security audit documentation was reviewed and indicated all weekly checks had been conducted; however, one form for one week was not fully completed.

The facility administrator (FA) was interviewed and indicated the process to identify and track safety and security deficiencies and how they are addressed by the program is to complete weekly safety and security inspection forms done by the physical plant manager or designee. The document is reviewed by the FA. Completion of projects/corrections of deficiencies are documented on the report as well.

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

The program has a policy and procedures addressing the issuance, inventory, and control of equipment and tools. The program did not allow youth to utilize tools during the annual compliance review period. The annual compliance review team observed all tools were securely stored, marked for easy identification on a shadow board and inventoried prior to being issued for work, as well as following work activities. The last six months of inventories were reviewed. All tools which were not sharp-edged or pointy were inventoried monthly. Sharp-edged/pointed tools were inventoried daily; prohibited tools include machetes, bowie knifes, or long blade knifes. The procedures for missing or lost tools was followed and dysfunctional tools were disposed of or replaced, as needed. The program places a tag on the spot the broken tool would be hanging, to identify the reason it is not present. All seven pre-service and seven in-service staff training records indicated they received training in the intended and safe use of tools.

Seven youth were interviewed regarding what kind of tools, if any, are they allowed to use. All seven indicated they can use mops and brooms; three stated a scrub brush and two said they are not allowed to use tools.

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 does not allow youth to use tools but has a policy and procedures for the supervision requirements in the event they do allow youth to use tools. The procedures include the issuance of tools to youth and staff, including the completion of an assessment to determine the youth’s risk to self and others, as well as staff to youth ratio.

All seven reviewed youth records contained a risk assessment for each youth. Youth receive risk assessments at least once a month. Seven staff were interviewed and asked what tools youth are allowed to use. All staff stated youth are not allowed to use tools, but can utilize mops and brooms, and five said youth can use a scrub brush.

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

The program has a policy and procedures for tool management and incorporated external contractors, which included maintaining vigilant supervision of the youth and limit youth access to areas when the outside contract workers are on-site with tools. The procedures included the physical plant manager to be responsible for providing the contractor with a notice of tool/equipment instructions prior to any contracted work occurring and ensuring the contractor signs the form signifying the review of instructions.
A review of the last six months of sign in and out logs, as well as signed written notification for outside contractors was conducted. Eight out of a total of fifteen visits from outside contractors were missing a written notification for outside contractors.

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

The program's Continuity of Operations Plan (COOP) indicates evacuation/emergency/fire drills are to be conducted once a month on each shift. During the annual compliance review period, the program was on two shifts. A review of the last six months of drills indicated the program completed one drill on each shift, each month, with two exceptions. The following fire drills were missing: second shift in June and August 2019. The program has fire evacuation routes posted throughout the program and all fire extinguishers were inspected annually.

The facility administrator interview indicated the COOP drills are completed monthly across each shift, as well as the fire drills. Seven interviewed youth indicated they were instructed on the fire evacuation process. Seven staff were interviewed regarding what type of drills they had participated in within the last twelve months. Six indicated fire drills, four said weather, and COOP, three indicated major disturbance, chemical spills, escape, two stated mental health and one said bomb threat and flooding drills.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature. *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 Continuity of Operations Plan (COOP) is maintained in master control for staff to review if needed and included the provision of equipment and supplies required for continuous operation and services during emergency/disaster situations, as well as all required new COOP information. The plan was reviewed and updated on March 25, 2019 and addresses alternative housing plans approved by the applicable Department regional director/designee. The COOP

and disaster plan are one combined plan and was submitted to the Department for approval on March 19, 2019. The program maintains a hard-copy file with information in the case management office for each youth assigned to the program, in case of emergency resulting in the program relocation or when information cannot electronically be accessed. A review of the hard copy file indicated all required youth information was present.

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

The program has a policy and procedures which describes the storage and inventory of flammable, poisonous, and toxic items and materials, as well as provides a list of program staff positions authorized to handle these items. During the annual compliance review, a review team member observed three locked cabinets in the sally port area which contained the flammable, poisonous, and toxic items and materials used by the program. The area is inaccessible to youth, inventories on all items were maintained for the last six months and the items present in the storage area matched the inventory. The program has safety data sheets for all onsite materials.

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

The program has a policy and procedures which describes the process for youth handling and the supervision of flammable, poisonous, and toxic items and materials. The program maintains the strict control of these items. The procedures indicate youth do not use, handle, or clean-up dangerous or hazardous materials, bodily fluids, or human waste. The program restricts youth access to areas where items are being used or stored.

Seven youth were interviewed regarding what items they handled. All stated they do not use chemicals or cleaning products. One said she had used paint while being supervised by staff.

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

The program has a policy and procedures for the disposal of flammable, toxic, caustic, and poisonous items which included a list of staff positions who are authorized to dispose of these items, as well as those procedures in accordance with Occupational Safety and Health Administration (OSHA) Standards. The procedures also indicated chemical spills are cleaned-up upon becoming aware of them and notifying master control of the location. The shift supervisor/master control shall direct the shut-down of all air handlers and ventilation system

and close all windows and doors at the direction of the on-scene supervisor. Assistance from outside the facility shall be contacted, as necessary, consistent with emergency procedures. The physical plant manager is the person who is authorized to dispose of flammable, toxic, caustic, and poisonous items and received on the job training regarding the appropriate disposal of these materials. The program stores the hazardous liquid waste as required and disposes of it as indicated on the safety data sheets. Liquid waste from work details is disposed of in the plumbing drains. The program did not utilize their kitchen during this review period. The program's hazardous disposal log indicated there have been no items requiring disposal during this review period.

The facility administrator was interviewed regarding the program's disposal practice for flammable, toxic, caustic, and poisonous items. She indicated the program utilizes the Hillsborough County Solid Waste Management Division Household Hazardous Waste program. They are open to receive waste products the third Saturday of every month.
The maintenance staff was interviewed regarding the disposal practices within the program. The staff indicated there has not been any disposal of flammable, toxic, caustic and poisonous items since the last annual compliance review; however, the program contracts with Household Hazardous Waste program.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures to address visitation, correspondence and use of the telephone by youth, as well as alternative visitation arrangements for the parent/guardian. The program provides the visitation schedule in the youth’s handbook which is given to the youth on the day of admission, as well as provided to the parent/guardian. The mail log was reviewed; however, a review team member was unable to observe the search of any incoming or outgoing mail during the annual compliance review week. The program’s mail log has the name of the youth, mail being sent or received and the signature of the youth acknowledging the item being opened in their presence. The program conducts visitation on the weekend and the visitation log for the last six months was reviewed. The program completes a visitation documentation summary indicating the date of the visitation and the number of youth participating in the visitation. All visitors sign the visitor log when entering and leaving the

program. Each youth is assigned a day of the week to conduct the once a week telephone call, wherein the date, time started and ended is documented on the form.

Seven youth were interviewed regarding the chance to communicate with family members by mail/telephone or at visitation. All seven verified they have these opportunities.

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

The program has one controlled observation room which met the requirements. A sample of three controlled observation reports were reviewed. All three reports had the required documentation which indicated the date and time in/out, staff conducting an inspection of the room, and a female staff searching the youth, prior to placing the youth in the room.

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

The program's policy and procedures indicated the facility administrator is the designated supervisory staff to approve placement of youth in controlled observation.
In the last six months, the program reported controlled observation has been used eight times. A sample of three controlled observation reports were reviewed. None of the youth were exhibiting behaviors indicative of a mental health crisis. The youth were exhibiting active aggression towards others, violent behavior, physically out of control behavior, and staff needed to quickly gain control and order for program safety and security. In all three instances, supervisory staff authorized the placement, and a health status checklist was completed by a female staff; none required healthcare staff follow up. In two of three instances, the staff advised the youth for the reason of placement in controlled observation. None of the controlled observations for the last six months included a stay of over two 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 indicated the facility administrator is the designated supervisory staff to approve placement of youth in controlled observation. A sample of three controlled observation reports were reviewed. In all three, staff completed the first page of the controlled observation report and submitted it to the supervisor, as well as documenting all safety checks and observations on the form and determining if an in-house alert was needed. In two of three the staff conducted safety checks every fifteen minutes to observe the youth's behavior. In the remaining one, the youth was held in controlled observation for fifty minutes, and had one check conducted four minutes late, and another check conducted fifteen minutes late. In all three reports the facility administrator/supervisor gave written approval before the youth was released from controlled observation and a review by the facility administrator or assistant facility administrator was conducted within fourteen days of the youth's release from controlled observation. The controlled observation report, health status checklist, and controlled

observation safety checks were maintained in an administrative file, as well as in the youth's individual case management record.

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

The program maintains a safety plan for each youth in master control. The safety plans included all required areas. A review of seven youth case management records revealed none of the youth in the identified sample size were admitted to the program after July 1, 2019 when the Department's requirements changed regarding safety plans. A request was made to the program for additional sample of records for applicable youth. The program only had two youth who were admitted into the program after July 1, 2019. The two applicable safety plans were completed within fourteen days of admission and both contained the required elements. All nine safety plans were jointly prepared by youth, program's clinical staff, behavioral specialist, where applicable, and the parent/guardian where available, and updated every thirty days.

Seven staff were interviewed regarding where the safety plans are located and what review process is followed. Two staff said the safety plans are in case management, two others were unsure, two more thought they are in master control and the last stated they thought they are kept by youth in their room, on the module and in the classroom.

All seven interviewed youth stated they were involved in the development of their safety plan.