STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Lake Academy

TrueCore Behavioral Solutions, LLC.
(Contract Provider)
9504 E. Columbus Drive
Tampa, Florida 33619

Review Date(s): August 18-21, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Amanda Nelson, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Marvin Bliss, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Brenda Comadore, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Cindy Jones, Office of Education, Deputy Education Director (Standard 2)
Gregory Mahoum-Nassar, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Paul Sheffer, Office of Accountability and Program Support, Regional Monitor, (Standard 1)
Bonita Williams, Office of Accountability and Program Support, Regional Monitor (Youth and Staff Interviews)
Ron Warrick, Office of Education, South West Education Coordinator, (Standard 2)
Lynda Zweibach, Eckerd Connects, Director of Quality & Treatment Services, (Standard 3)

Program Name: Lake Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Hillsborough County / Circuit 13
Review Date(s): August 18-21, 2020

MQI Program Code: 1069
Contract Number: R2104
Number of Beds: 50
Lead Reviewer Code: 177

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

Overall Rating Summary
All indicators have been rated Satisfactory and no corrective action is needed at this time.

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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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, intensive medical overlay services, and borderline developmental treatment. In addition, the program fosters each youth by providing multiple curricula to support life skills, delinquency interventions, and gender-specific training. Treatment curricula includes: Girls in Real Life Situations, Living in Balance, Teen Relationships, Conflict Resolution from the Inside Out/Helping Teen Manage Conflict in the Real World, and Thinking, Feeling and Behaving. Additional treatment services provided includes Dialectical Behavior Therapy, weekly individual sessions, monthly family therapy, and therapeutic recreational art groups. Delinquency interventions are provided through Impact of Crime and Thinking for a Change curricula. Gender-specific programming is provided through the VOICES and Sisters Attracting Value Vision and You (SAVVY) Sisters curricula. Program administration is comprised of a facility administrator and one assistant facility administrator. Case management services are provided by director of case management, lead case manager, three case managers, and a transitional services manager. Mental health staff at the program includes a licensed clinical director, a licensed assistant clinical director, a licensed lead mental health therapist, four mental health master's-level therapists, one certified behavioral analyst, and a recreation therapist. Medical services are offered and are provided twenty-four hours a day, seven days a week by the health services administrator, five registered nurses, and one licensed practical nurse. The program contracts with Linton Food Services to provide all meals which are prepared at Tampa Residential Facility. Educational services are provided by the Hillsborough County School District. The layout of the program includes one main building which contains areas for administration offices, case management and mental health offices, a medical clinic, a cafeteria, a kitchen which does not prepare cooked food on-site, a centrally located master control room, three living units, and educational classrooms. The program has forty-nine operational security cameras providing coverage. At the time of the annual compliance review, the program had twenty-two vacant positions including twenty youth care workers and two youth care workers II positions.

Strengths and Innovative Approaches

- The program updated their treatment rooms with the assistance of staff and youth to provide a more welcoming and therapeutic environment which aided the youth in opening up more to staff. The program added curtains, décor, soothing paint colors, and furniture at the request of the youth who sensed the rooms had a "jail" environment which made them uncomfortable when speaking with mental health staff.

- The program has a therapeutic dog provided by the program's facility administrator to the program throughout the week, which provides youth with comfort and affection.

- The program updated the intake restroom with inspirational messages and bright colors to be more inviting to new admissions.

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 initial background screening. The program had fifteen newly hired staff since the last annual compliance review. There were seven volunteers and/or mentors applicable for an initial background screening. Reviewed documentation supported the fifteen newly hired staff and seven volunteers and/or mentors received background screenings completed by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each staff's date of hire and/or contact with youth or access to confidential information. Each reviewed employee record provided documentation indicating 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 (AMS) as part of the pre-employment background screening process. An interview with human resources revealed all current or prior staff are also investigated for any possible Prison Rape Elimination Act (PREA) allegations by a Department of Justice certified investigator. All fifteen newly hired staff and seven volunteers and/or mentors were added to the Clearinghouse employment roster. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the BSU on December 10, 2019, meeting the annual requirement. The Hillsborough County School Board's Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's BSU on December 4, 2019, meeting the annual requirement. Each direct care staff hired after July 1, 2018 is required to complete a pre-employment assessment and receive a passing score. The program had six direct staff hired after July 1, 2019, requiring a pre-employment assessment. The required pre-employment assessment is called the Burke. Documentation reviewed found a pre-employment assessment was completed by the six newly hired direct care staff and a copy of the passing score was maintained in each staff's personnel record.

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

The program has a policy and procedures for conducting five-year rescreening for all staff, volunteers, and interns in accordance with Department requirements. The program had one contracted staff member who met the requirements for a five-year background rescreening. The

contracted staff member had a rescreening completed prior to their five-year anniversary date, in which the information was submitted to the Department's Background Screening Unit at least ten days prior to the staff's member anniversary date. There were no volunteers, mentors, or interns 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 trauma responsive practices.*
- *The program shall complete or schedule a TRACE self-assessment.*

The program has a policy and procedures for abuse reporting and for providing an abuse-free environment. The policy stipulates youth and staff are to have unhindered access to report alleged abuse to the Florida Abuse Hotline without intimidation or reprisal. Observations during the facility tour revealed postings of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers throughout the program. The program also provides a telephone in the main hallway which dials directly to the Florida Abuse Hotline. The program's policy outlines the reporting procedures for all staff to follow when a youth would like to report abuse. The procedures for program staff indicate youth will be provided with timely access to report allegations of abuse without intimidation or reprisal. If the youth requests telephone access during a structured activity, they are to be provided access as soon as the activity concludes. Staff are never to prevent a youth from self-reporting or making a call to the Florida Abuse Hotline. Staff are to notify the shift manager or master control to inform them a youth is requesting access to the Florida Abuse Hotline or the CCC, as appropriate. Youth are allowed to freely communicate with the Florida Abuse Hotline or the CCC operator. Once the call has been completed, staff are to notify the shift manager or master control the youth has completed their call. A youth's refusal to make the abuse call themselves does not relieve the staff from their mandate to call the Florida Abuse Hotline, if the staff has reasonable suspicion abuse has occurred. The program completed a Trauma Responsive and Caring Environment (TRACE) Self-Assessment in March 2020. The results of the self-assessment coupled with survey information, were reviewed with all staff at the June monthly meeting. Upon hire, all staff acknowledged their receipt and understanding of the code of conduct in the provider's electronic

personnel system. A resident handbook is provided to each youth upon admission. The handbook includes the youth's rights, the program's grievance process, and the Florida Abuse Hotline and CCC telephone numbers. A review of documentation for the annual compliance review period was conducted for allegations of abuse to the Florida Abuse Hotline or CCC; twenty-six reports alleging abuse were found. Documentation reviewed found four of the reports had substantiated findings. Two of the incidents were substantiated due to use of force, one due to falsification, and another for a violation of policy. Staff were disciplined and/or terminated in each of these situations. Nine of the reported incidents had unsubstantiated findings, while the remaining thirteen reports were still pending. Seven were assigned for a program review, three were assigned for a management review, two were assigned to the inspector general, and one is still pending assignment.

An interview conducted with the facility administrator (FA) confirmed the program's code of conduct. The policy includes specific standards of conduct which staff must follow. The FA indicated failure to follow the standards of conduct may result in disciplinary action from an oral warning to termination of employment. The severity of the penalty depends on the frequency and nature of a particular offense. The various disciplinary actions are taken when physical abuse, threats, or profanity are used towards youth. The FA also shared the program's trauma responsive environment policy. The policy and reviewed documentation supports the program began looking into each youth's individual traumas during the intake process. Assessments are conducted and the findings are utilized during the classification process. The program then utilizes the information to assist each youth to develop their individual safety plan. The safety plans are used by the treatment team to ensure therapeutic value, practicality, and accessibility. The plans are reviewed at a minimum, during each formal treatment team meeting. Additionally, the FA was able to share the completion of the TRACE Self-Assessment. This tool is completed annually to determine where improvements can be made and to assist with future action planning. The FA also confirmed the program's incident reporting process matches the program's policy and procedures.

Interviews conducted with five staff to determine their knowledge allowing youth to make a call to the Florida Abuse Hotline indicated each staff allowed youth to make a call if requested, and staff will involve a shift manager in the process. Two staff indicated they are allowed to call the Florida Abuse Hotline. Three staff stated they must notify the shift manager, while one stated they are to notify the FA. None of the five staff indicated ever observing a co-worker deny a youth the opportunity to call the Florida Abuse Hotline. Two of the interviewed staff indicated hearing a coworker using profanity and/or threats, intimidation, or humiliation when interacting with a youth. Both staff indicated the staff is no longer employed with the program. The remaining three staff stated they have never heard or observed staff act in this way.

Interviews with five youth revealed all feel safe in the program. Individual responses indicated youth feel staff are always around and youth are always able to talk with staff or call the Florida Abuse Hotline. The youth appreciate when administration becomes involved, when needed. None of the youth reported ever being stopped from calling the Florida Abuse Hotline and three youth indicated never needing to call. All five youth reported staff are respectful when speaking with them and none of the youth have ever heard staff use profanity. When questioned if they had ever exchanged emails, telephone numbers, or social media information with staff, all five youth reported no.

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 ensuring management takes immediate action to address incidents of physical, psychological, and emotional abuse. The program's practice is to initiate an internal investigation regarding the complaint and remove the staff member from youth contact, when necessary. Corrective action may include oral warnings, written disciplinary actions, suspension, and/or termination for any substantiated incidents. An interview with the facility administrator (FA) confirmed this practice. A review of documentation for the annual compliance review period was conducted for allegations of physical, psychological, or emotional abuse to the Florida Abuse Hotline or CCC; twenty-six reports alleging abuse were found. A review of documentation for five of the incidents found management took appropriate and immediate action by initiating an internal investigation regarding staff on each allegation of abuse. Documentation confirmed staff were removed from youth contact, as appropriate. All five of the reviewed reports were found to be unsubstantiated for abuse; however, one of the reviewed incidents was substantiated for violation of policy. This staff member was reprimanded and provided with retraining. Documentation confirmed the staff was suspended as a result of the investigation. An internal investigation has not been completed for the one other staff who does not currently have direct contact with youth pending the outcome of the internal investigation.

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 regarding reports to the Department's Central Communications Center (CCC). The program had thirty-nine incidents reported to the CCC during the last six months, of which five were reviewed. Fourteen of the thirty-nine incidents were related to COVID-19 reporting procedures. A review of five non-COVID related incidents found documentation validated each of the five incidents reviewed were reported to the CCC within the mandatory two-hour time frame and in accordance with CCC reporting procedures. The program maintains a master logbook for documenting reports to the CCC and a review of the logbook supported all five incidents were documented in the logbook. A review of internal incidents for the past six months determined there were no incidents which should have been reported to the CCC which were not. A comparison of reportable incidents during the same time period last year confirmed a decrease of reportable incidents from sixty-four incidents, during the same time period last year, to thirty-nine incidents this year. The facility administrator (FA) reported, all staff and volunteers of the program shall adhere to the Florida Department's Rule relating to the reporting of incidents and the program's procedures for reporting incidents which are not required to be called into the CCC. The FA ensures any matter requiring reporting to the CCC shall be verbally reported within two hours of the incident or learning of the incident. If there is doubt at any time as to whether an incident or event is reportable, the presumption shall be the incident or event is reportable and shall be reported. The program maintains a separate file of all incident reports and has a system in place for tracking all incidents.

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

The program has a policy and procedures for the use of Protective Action Response (PAR) by staff. The program had fifteen PAR incident reports during the last six-month period. Five were selected for review. All five reports were completed by the end of the staff member's workday. All five reports included all required written statements by each staff involved in the incident while one report was missing a statement from one involved staff member. All required reviews were conducted and documented by the supervisor on-duty at the time of the incident and by a PAR-certified supervisory staff member within the required time frames. All five PAR reports were reviewed within seventy-two hours of the incident by the facility administrator (FA) or designee. Each report reflected a post-PAR interview was conducted with each of the youth within thirty-minutes of the incident by the FA or designee to assess the need for further medical review. There were concerns with two of the five youth and each was seen by nursing staff for a post-PAR medical review. The program's PAR plan was submitted and approved by the Department's Office of Staff Development and Training on January 10, 2020. Reviewed documentation validated the completion of monthly PAR reports which were submitted to the central region office of residential services by the fifth of each month. The program's PAR rate during the annual compliance review period was 6.63, which is above the statewide Residential PAR rate of 2.28. The program experienced a large increase in their PAR rate from 2.04 on the last annual compliance review to the current rate of 6.63. The FA stated, the increased PAR rate was due to a small group of youth who entered the program at the end of 2019 who caused major disruptions and attempted self-harm. This group of youth also caused property damage and eventually were transferred to higher risk programs. The FA confirmed the program has a process for monitoring and tracking PAR incidents and use of force. All PAR incidents and use of force are discussed in the daily management meetings and documented in the meeting minutes. All PAR reports are reviewed by management and filed within forty-eight hours of signing. On the fifth of every month, the PAR monthly summary report is sent to the provider designee and the Department.

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

The program has a policy and procedures addressing pre-service training. The program maintains a pre-service training plan and calendar for all new staff which was submitted to the Department's Office of Staff Development and Training on February 7, 2020 and approved on February 17, 2020. Pre-service training is provided through a combination of instructor-led, web-based courses, and on the job training. Five staff training records were reviewed for pre-service training. All five records reflected staff completed the certification process within 180 days of hire and completed all required trainings inclusive of Protective Action Response (PAR), first-aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, Human Trafficking, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. A review of all five staff training records confirmed documentation to support each staff

exceeded the required 120 hours of pre-service training. All contractual required trainings were completed for all five staff reviewed. Job specific training was also completed by one applicable staff. Documentation confirmed all training was delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro) within thirty days.

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 was submitted to the Department's Office of Staff Development and Training on February 7, 2020 and approved on February 17, 2020. Five applicable staff training records of which two were supervisor's training records were reviewed for in-service training. Each reviewed staff training record documented each staff exceeded the twenty-four hours of in-service training requirements. Each staff had current certifications in first-aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff also completed training in professionalism and ethics, including standards of conduct, suicide prevention, and annual active shooter training. Four of the five staff records reviewed had the required annual human trafficking training, one staff member had not received human trafficking training in the previous calendar year. Two of the five staff records reviewed were supervisor training records to confirm the completion of eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, communications skills, and fiscal. Reviewed documentation supported each supervisor exceeded this requirement. All trainings were delivered by qualified trainers and documented in the Department's Learning System (SkillPro) within thirty days.

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

The program has a policy and procedures outlining the grievance process for the youth to formally file complaints about conditions, treatment, services, and the actions of program staff and other youth which are in violation of the youth's rights. The policy also helps to ensure complaints are reviewed in a fair and expeditious manner and are resolved in the best interest of the youth, the program, and the Department of Juvenile Justice. The grievance process includes three phases: informal, formal, and appeal. Staff are trained on the process during their pre-service training and annually, thereafter. A review of ten staff training records were reviewed to confirm staff received training on the grievance process. Five staff were reviewed for pre-service training in the grievance process and five staff were reviewed to confirm they completed annual in-service training in the grievance process. All ten records contained the required grievance training. The program uses "Chatty Cathy" forms as part of the informal process. The policy indicates youth are encouraged to resolve questions, disputes, or complaints through

informal communication with program staff. Staff are required to make a reasonable effort to assist the youth with their concern. If the youth does not feel comfortable speaking with staff, they can fill out a “Chatty Cathy” form to request a particular staff they would like to speak with. The requests are typically resolved within twenty-four hours, but no later than seventy-two hours after submission. If a youth is not satisfied with the outcome of the informal complaint or they feel the concern is more serious, they can fill out a formal grievance form. The informal and formal grievance forms were available in the youth dormitory areas and the cafeteria. The program requires formal grievances be processed by the program’s grievance officer, the assistant facility administrator (AFA) or designee within seventy-two hours of submission. If the grievance is unable to be resolved with the youth, the grievance enters the appeal phase. The facility administrator (FA) will address all appeals within seventy-two hours of the formal decision. Forty-three grievances were submitted during the annual compliance review period. All grievances for the past year were maintained within a binder, separated by month, and documented as set forth in the grievance policy on their internal tracking form. Five grievances were reviewed. Two of the grievances indicated the youth used the informal phase prior to the formal phase; however, each were addressed within the required seventy-two hours by the AFA. In each situation, the complaint was resolved at this phase. Interviews with five youth confirmed the forms can be found in the cafeteria area, along with the locked box to place them in. The youth shared they will place the completed form in the grievance box and a member of administration will remove the grievances from the box and meet with the youth within twenty-four hours. The youths’ comments each reflected understanding of how the forms are handled after being placed in the grievance box. All five youth confirmed they can request help filling out a grievance form; however, only one of the youth could describe the different phases of the system. Five staff were interviewed regarding the grievance process. Each staff were very clear about the location the forms are placed and each were aware a supervisor addresses them, once submitted. Three staff reported youth could request assistance in filling out the form and two were knowledgeable of the time frames associated with the forms. None of the five staff were knowledgeable of the three different phases specifically. An interview with the FA confirmed the grievance process by indicating youth place completed forms in the grievance box which is found in the cafeteria. This box is checked each day by the AFA or designee, who will attempt to resolve the concern as soon as possible.

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

The program utilizes Impact of Crime (IOC) and Thinking for a Change (T4C) as their delinquency intervention curricula. According to the Department’s Sourcebook of Delinquency Interventions, both IOC and T4C are listed as promising practices which are the only two delinquency interventions offered at the program. Interviews with the facility administrator (FA) and the clinical director confirmed these are the delinquency interventions offered by the program. The two curricula in addition to individual counseling, are the program’s primary services offered to youth. The review of five youth case management records found four of the youth completed IOC while in the program. The remaining youth was found to have attended IOC during a previous commitment placement. The program currently has two staff who facilitated IOC and two staff who facilitated T4C during the annual compliance review period. The program’s previous recreational therapist was trained to deliver both IOC and T4C. The

review of training documentation found each staff were trained by a qualified trainer, to deliver the respective curricula. An interview with the FA revealed they choose group facilitators by targeting individuals who present with desirable attributes and experience which will support the youth and acknowledge their life experiences. All facilitators were found to have at least a bachelor's-level degree and are trained in the curricula they are facilitating. A review of sign-in sheets, observations of program activities, and the program's schedule, found the program is providing structured, planned programming and activities for at least sixty percent of the time youth are awake. The reviewed schedule also found each of these groups were offered as indicated on the program's schedule. Neither curriculum was currently being offered, as each group had recently finished. The program indicated the next IOC group will begin on September 7, 2020, with six youth selected for the group. The program does not have a start date for the next T4C group selected at this time. The program indicated youth are placed in a specific group based upon their individual therapeutic needs. Once the youth has been classified and assessed to identify the criminogenic needs of each youth, the program decides which group each youth will be assigned to complete while in the program. An interview with the FA confirmed these services are being followed to address the needs of the youth, as identified through screenings conducted during admission. Three of the five interviewed youth indicated they participated in one of the delinquency interventions offered by the program.

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 in place regarding life skills training provided to youth. The program provides a wide variety of interventions focusing on the development of life and social skills in youth. The clinical staff facilitates the following curricula to foster life skills growth for the youth such as VOICES: A Program of Self-Discovery and Empowerment for Girls, Thinking, Feeling, and Behaving, Dialectical Behavioral Therapy (DBT) Skills Training, Conflict Resolution, Teen Relationships, Sisters Attracting Value Vision and You (SAVVY) Sisters, and Social Success. A review of five staff training records found all group facilitators were trained to deliver their respective curricula, with all facilitator's being a master's-level therapist. The groups address skills streaming, communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, substance abuse, critical thinking, and problem solving. A review of group sign-in sheets confirmed the clinical mental health overlay services groups are held seven days a week, as required. Interviews with five youth confirmed attendance in groups such as VOICES, anger management, social skills, teen relationships, and emotional recognition. The youth stated they learned new skills on how to deal with anger, coping skills, different ways to express feelings, and strategies for relapse prevention. They also indicated they role play during group activities to work on the new skills learned and each share personal strategies used to put their new skills to use. An interview with the clinical director confirmed the therapists follow the group schedule and indicated weekly fidelity checks are conducted on the provided groups. A review of five youth case management and mental health records confirmed each youth received services, as outlined in their individual performance and treatment plans.

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

The program has a policy and procedures regarding restorative justice awareness for youth. The program provides the Impact of Crime (IOC) curriculum in addition to community service projects, which helps to increase awareness and empathy for crime victims and survivors. The program indicated youth who are identified with gang affiliation are prioritized to participate in IOC before they are discharged. A review of group sign-in sheets confirmed the curriculum was delivered appropriately. A review of training records documentation found IOC facilitators were trained by a qualified trainer to deliver the curriculum. The program recently completed a cohort of IOC and is scheduled to begin the next session on September 7, 2020. The program typically uses community service projects to enhance the lessons learned regarding restoring victims and their communities. These projects and opportunities for outside speakers, have been limited since March 2020, due to the COVID-19 pandemic. A review of activities before the pandemic reflected regular community service outings and opportunities for the youth to serve others. Since the start of the pandemic, youth have worked on hand-made cards for first responders and other essential personnel in the community. Examples of these hand-made cards were shared with the annual compliance review team. Some youth also participated in a recent Zoom meeting entitled: "iCare About Me: Teen Town Hall Series." The meeting included the Mayor of Tampa, Department of Juvenile Justice staff, and members of the school board. During this meeting, youth were able to provide feedback about improving communities, improving race relations, and eliminating barriers. Five youth were interviewed about their participation in restorative justice curricula. Four of the five youth confirmed their participation in IOC. The remaining youth completed IOC in another program. The facility administrator was interviewed and confirmed youth participate in IOC and community service projects for restorative justice awareness.

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

The program has a policy and procedures regarding gender-specific programming. 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. The program provides VOICES: A Program of Self-Discovery & Empowerment as their gender-specific curriculum, as required by contract. This curriculum encourages youth to see their "true selves" by providing a safe space, encouragement, structure, and support as they take a journey of self-discovery. The program also provides the Sisters Attracting Value Vision and You (SAVVY) Sisters and Girls in Real Life Situations (G.I.R.L.S) curricula. The groups focus on assisting youth in recognizing values and skills they may be missing in their lives while enhancing their social and emotional development. Each of these groups are delivered by the program's clinical staff. A review of the training records for all clinical staff confirmed each staff was trained to be a facilitator for these groups. A review of sign-in sheets and group progress notes in addition to a review of the daily activity schedule, confirmed each of these groups are provided weekly. The nursing department has implemented the "Lake Awareness" wall located outside the medical clinic. The space is used to provide information

regarding a different health topic each month. Youth can participate in decorating the wall while learning about specific health topics. Recent topics featured includes cervical cancer awareness, self-injury awareness, breast cancer awareness, domestic violence, and health/nutrition. An interview with the facility administrator confirmed the program's philosophy on working with youth to address their specific needs as young women. An informal interview conducted with the clinical director, confirmed the clinical staff offers the gender-specific curricula to the youth. Interviews with five youth confirmed they are attending groups to include the VOICES curriculum. The youth also indicated they have opportunities to practice the skills learned in groups.

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

The program has a policy and procedures addressing the internal alert system and alerts entered into the Department's Juvenile Justice Information System (JJIS). An interview with the program's facility administrator (FA) reflected JJIS alert reports and the program's internal alerts are reviewed daily by administrative staff during the daily morning management meeting. The program maintains an alert board in the staff break room, where shift briefings are held. The alert board was found to contain key alert information including youth who are a security or safety risk, health-related concerns, food allergies or special diets, and suicide or mental health alerts. The board is updated as needed by medical, clinical, and case management staff. Additionally, the program maintains a medical alert log which is updated when changes occur, by nursing staff. A review of documentation and observations during the annual compliance review, confirmed the alert board and medical alert log are updated by the shift supervisor at each shift briefing for oncoming staff. A review of five youth records to include their individual health care records, mental health and substance abuse records, and youth case management records indicated all youth with applicable alerts relating to mental health, suicide risk, medications, special diet, allergies, no strenuous activity, and gang member/gang association were entered, and removed when applicable, in JJIS. No discrepancies were identified when comparing the internal alert system with JJIS alerts for the five reviewed youth. A review of the program's policy and an interview with the FA reflected suicide risk and other mental health alerts are only downgraded by clinical staff, medical alerts are only downgraded or changed by nursing staff, and security alerts are only adjusted by the FA, assistant FA, or supervisory staff. The review of alert information confirmed this practice. A review of the logbook found all pertinent alert information recorded appropriately, with one exception. There was one suicide risk alert which was not carried over at the beginning of a shift; however, the youth was stepped down to standard supervision during the shift where the exception was found. Interviews with five staff confirmed youth alert information is shared daily through shift briefings and the alert board.

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

The program has a policy and procedures regarding the creation, maintenance, and storage of individual healthcare records, mental health and substance abuse records, and case management records for each youth at the program. The program maintains individual, color coded, hardbound binders utilized for case management, mental health and substance abuse, and healthcare records. Reviewed documentation of five youth records found each was labeled "confidential" and were secured in file cabinets identified as "confidential" in the assigned locked offices and medical clinic, which are inaccessible to youth. Observations of the records reflected each youth record had the required documentation on the spine and on the front cover of the binder to include the youth's name, date of birth, county of residence, date of admission, committing offense, and the Department of Juvenile Justice identification number. Reviewed records reflected all required information was maintained in chronological order within each record. Documents and information were organized into required sections and separated into designated sections with tabs for legal information, demographic and chronological information, case management, treatment team activities, correspondence, and miscellaneous.

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

The program has a policy and procedures regarding youth input. The program provides many avenues for youth to provide input about the program. The program holds daily community meetings for each dorm, which are led by youth to provide a platform to share praises, announcements, and talk about any current issues. The youth can also use the "Chatty Cathy" forms to resolve any concerns they may have at any time. This is part of the program's informal phase of their grievance process. The program also have a youth advisory board, which meets bi-weekly with the recreational therapist and/or the restorative justice counselor. A review of the meeting minutes and sign-in documentation reflected the youth advisory board met every other week for the past six months. The reviewed documentation reflected youth provide input regarding what types of items are offered as rewards, different incentives which should be offered to youth, and sharing ideas about different types of off-campus activities. In addition, youth are provided surveys each quarter. The information gathered from the surveys is shared with the management team to help make enhancements or changes based on input from youth. The facility administrator (FA) shared how youth input was a large factor in the decision to change food vendors due to overwhelming concerns shared by the youth through the surveys and other means. Each of the five interviewed youth indicated the program has a process for them to provide input about what happens in the program. Responses from the youth indicated they can speak with staff, share concerns in community meetings, fill out "Chatty Cathy" forms, or share concerns with the youth advisory board members. An interview with the FA confirmed the youth advisory board provides an opportunity for youth to take some ownership in strengthening the program while teaching problem solving, decision making, and teamwork.

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

The program has a policy and procedures for maintaining an advisory board. Reviewed documentation reflected the program participated in quarterly board meetings with two other programs located on the same campus, Hillsborough Girls Academy and Tampa Residential Facility. This practice of holding meetings together was approved by the assistant secretary of Residential Services on March 8, 2017. A review of documentation reflected the meetings were held November 14, 2019, February 13, 2020, and May 14, 2020. Reviewed documentation reflected consistent attendance by members of the business community, school board, and members of the faith community. The program was able to present documentation reflecting emails and other correspondence to solicit active involvement of other interested community partners. These included law enforcement representatives, local judges, a member of the LGBTQI community, a victim advocate, and the parent/guardian of a child previously involved in the juvenile justice system. The reviewed meeting minutes reflected specific information being shared for each of the three programs involved. An interview with the facility administrator revealed they have reached out multiple times to interested parties and were able to provide documentation of the follow-up communication. Unfortunately, the invitees were unable to attend for various reasons. An interview with a board member was unable to be conducted during the annual compliance review.

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

The program has a policy and procedures in place regarding program planning designed to establish a system of communication, facilitate staff involvement, discuss program issues, and the development of policies, procedures, and programs. The program solicits information from youth and their parent/guardians utilizing surveys, which can be completed electronically through Survey Monkey or through completion of a paper copy. Each youth's parent/guardian is sent an admission survey to complete after each youth's intake. The program uses the surveys to gather information regarding the program's admission process and customer service practices. Conversely, once a youth is discharged from the program, the parent/guardian for each youth is provided with a family satisfaction survey. Both the admission and discharge summaries are returned to the company's chief compliance officer. The chief compliance officer reviews the survey results and distribute the results to the facility administrator to provide information and feedback for the staff. Staff surveys are conducted on a quarterly basis. They are used to gather information regarding working conditions, program practices, and general knowledge of staff pertaining to the requirements of their position. Youth surveys are also completed on a quarterly basis. They are used to gather information on how youth feel about how well the program is functioning. The staff and youth survey information are compiled at the corporate level by the information systems project manager and is disseminated to the facility administrators. Reviewed documentation reflected the program conducts monthly all-staff meetings, monthly supervisor meetings, and daily management meetings to share information with staff and to enhance program planning. Staff can communicate input and provide feedback on the program's operations during these meetings or at any given time with program's administrative staff. Documentation of all-staff meeting minutes confirmed the program reviews the Monitoring and Quality Improvement reports, any applicable major issues, medical updates, mental health updates, drill reviews, policy reviews, human resources issues, and safety and

security issues with staff. Survey results from staff, youth, and parent/guardians are also shared at staff meetings. The review of meeting minutes also confirmed the review of the Comprehensive Accountability Report (CAR) in March 2020 and the Trauma Responsive and Caring Environment (TRACE) results in June 2020. A review of daily management meetings reflected the management team discussed programming issues, incident reports, grievances, Central Communications Center reports, youth issues, education issues, Protective Action Response (PAR) incidents, program trends, alert trackers, sick calls, and staff vacancies. The program has a policy and procedures in place for employment recognition. An informal interview with the facility administrator and the program's regional compliance manager confirmed they have practices in place to minimize staff turnover. They shared information regarding the TrueCore Way Recognition Rewards. This is a way for staff who go above and beyond to be recognized for their positive performance. Staff names are drawn from all eligible nominees at each monthly all-staff meeting. The winners can order additional program shirts or a jacket in recognition for their hard work. They have an employee referral bonus program in place to encourage staff to earn monetary incentives for helping bring new staff to the program.

Interviews with five staff confirmed the program holds monthly staff meetings. The staff also indicated some departments hold meetings more often. The five interviewed staff indicated implementation of new ideas, human resources information, training on documentation, new information, trends with youth behaviors, medical updates, clinical information, and COVID-19 have been discussed during monthly staff meetings. Three of the five staff indicated they are briefed on annual reports and parent/guardian survey results while two stated they are not. One staff reported the communication at the program is very good, three reported it as good, and one reported it as fair. The five interviewed staff were able to explain their ability to provide input and feedback into the program operations. Each staff reported staff can speak with administration to provide any feedback or suggestions they have at any time.

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

The program has a policy and procedures in place which outlines requirements for evaluating staff performance annually and upon completion of the first ninety-days of hire. A review of position descriptions confirmed job duties are clearly outlined for each staff member. A review of five in-service staff personnel records found each staff received an annual performance evaluation. Each staff were evaluated based on established performance standards outlined in the position descriptions which they received and signed upon hire. All required positions in the program's contract are maintained and performed as required based on the position descriptions and reviewed documentation. The human resource manager and facility administrator (FA) confirmed evaluations are completed after the first ninety days and annually thereafter. The FA confirmed staff may receive more than one annual evaluation during a year, as deemed appropriate by the supervisor. Five staff were interviewed and four confirmed during the annual compliance review period, they received their ninety-day evaluations. One staff reported not receiving an evaluation yet. The program has experienced a great amount of turnover during the annual compliance review period while most of the direct care staff were hired during this time as well.

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

The program has a policy and procedures outlining the provision for recreation and leisure activities which are appropriate for youth at the program. A review of the program's activity schedule documents youth are given the opportunity to participate in a wide-range of indoor and outdoor recreation and leisure activities. During recreation time, youth participate in the prescribed activity on the recreation calendar or an alternative indoor workout of the day if weather does not permit outside time. In the evenings and on weekends, youth are given a choice of leisure activities. Youth are encouraged to explore interests during recreation and leisure time. Youth are afforded opportunities to provide input into offered activities through the youth advisory board, daily community meetings, and "Chatty Cathy" forms. Observations during the annual compliance review and documentation in the master control logbook confirmed recreation is provided daily. An interview with the recreation therapist confirmed the youth give input on planned activities and works hard to follow the schedule which is put in place each month, weather permitting. Observations of recreation and an interview with the recreation therapist reflected the program taking steps to prevent over-exertion, heat stress, or dehydration. Three coolers are taken outside when recreation is conducted. One has ice, another has ice water, and the third contains a sports drink which has electrolytes. Interviews with five staff revealed the youth are provided with at least one hour of outdoor recreation, weather permitting. Outdoor activities include kickball, basketball, volleyball, four square, walking, and football. Indoor activities include musical dodgeball, cornhole, and bingo. Five youth were interviewed and each reported being provided at least one hour of recreation time daily. Outdoor activities were reported to include catch the flag, volleyball, workouts, flag football, kickball, and basketball. Indoor activities included four square, dodgeball, and workout challenges. One interviewed youth indicated there is a schedule for recreation activities which they follow.

The program's contract requires a recreation therapist. The program's recreation therapist has a bachelor's-level degree in physical education, which meets the requirements in the program's contract. A recreation schedule was found outlining daily activities. In addition, the recreation therapist created workouts for youth when weather conditions did not allow to be outside. An incentive schedule was also created by the recreation therapist and posted throughout the program to allow youth to see the daily activity they could participate in with good behavior. During the annual compliance review, the review team observed youth engaged in outdoor activities such as basic stretching, workout routines, and youth playing four-square. A review of documentation for each of the five youth, confirmed each had a wellness plan developed by the youth and the recreation therapist. The plans allowed youth to set personal goals for their own physical wellbeing. Each plan was found to be incorporated into their Individualized Mental Health and Substance Treatment Plan. The progress on their goals were reviewed at each formal treatment team meeting.

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 parent/guardians and court notification. Five youth case management records were reviewed. Each record included supporting documentation on each parent/guardian being contacted by telephone 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 five records contained notification to the court and the juvenile probation officer the same day of the youth's admittance to the program. Notification was also made to the post-residential services counselor, when 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. Five 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 five 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. One admission was scheduled and observed during the annual compliance review. The program's orientation process was observed to be in compliance with policy and procedures for youth orientation. Five youth were interviewed and each reported having an orientation completed within twenty-four hours of admission.

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

Five youth case management records were reviewed and two youth were applicable for youth over the age of eighteen. Documentation for both records indicated the program had written consent before discussing physical or mental health screenings, assessments, education, and treatment with the youth's parent/guardian or any other individual for the duration of the youth 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 reassessment 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, and suspected risk factors for suicide, medical, escape and/or security. Five 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 medical, mental health, substance abuse, and security alerts were recorded in the programs internal alert system. Additionally, each youth alert corresponded with their respective classification form and entered into JJIS. All five 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 monthly treatment team meeting. During the annual compliance review, a treatment team meeting was observed confirming the program's practice. A review of all five 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. Due to the COVID-19 pandemic, no youth were eligible to participate in an off-campus activity for the past six months. An interview with the facility administrator was conducted and confirmed assessments are used to determine assignment to living unit, sleeping room, and youth group or staff advisor. Initial classification includes alert system status when the youth enters the program. This classification normally based on initial screening includes reviews of the commitment packet, risk factors, other information about the youth's history, youth status, initial collateral contacts, initial interaction with youth, and observation of youth.

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. Five 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 youth were from other counties. All three youth records included

written gang involvement notifications to local law enforcement and law enforcement to their home county, the educational program, and the youth's juvenile probation officer upon identification. The Department's Juvenile Justice Information System (JJIS) alerts were reviewed, all three youth alerts regarding gang affiliation status were added into JJIS alert system. An interview with the facility administrator (FA) indicated identification of youth to participate in gang prevention or intervention activities shall be based on information obtained through the program's screening, assessment and classification processes, as well as gang-associated behaviors exhibited or the youth's expressed interest or intent while in the program. The FA is also responsible to ensure the program shares pertinent gang-related information, as appropriate with the Florida Department of Law Enforcement, local law enforcement, Department of Corrections, school districts, the judiciary, and social service agencies as well as with a youth's juvenile probation officer (JPO) and, if identified, the youth's post-residential services counselor.

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. Five youth case management records were reviewed. One of the five youth case management records had a youth identified with gang affiliation. The program provided two additional youth records with gang affiliation identified. All three applicable records had a performance plan which included a gang intervention goal. All three records reviewed had documentation to support the youth were currently working on gang intervention strategies and documentation to support the youth had been provided and were completing gang assignments. 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 indicates they use the Changing Course-Preventing Gang Membership book in their prevention efforts.

An interview with the facility administrator (FA) indicated youth shall be educated on the negative consequences of gang membership and activity through victim awareness groups, as well as social and life skills groups. All gang graffiti shall be cleaned and removed within twenty-four hours of discovery. Additionally, the FA is responsible for ensuring gang prevention and intervention strategies are implemented in the program when youth are identified as being a criminal street gang member, affiliated with any criminal street gang, or are at high risk of gang involvement.

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 program is required to complete initial assessments for each youth within thirty days of admission. Five youth case management records were reviewed and all five were applicable for completion of an initial RAY. All five initial assessments were completed in advance of the required time frame and maintained in the Department's Juvenile Justice Information System (JJIS). The program completes a RAY reassessment every ninety-days after completion of the initial assessment. All five youth were applicable for a RAY reassessment and the RAY reassessments were completed within the required time frame. All five 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. Five youth case management records were reviewed. Each record contained a YNAS completed within the required time frame 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 developed. Five youth case management records were reviewed. All five youth records contained an IPP developed within the required

time frame. Each IPP included input from the treatment team leader, administrative representative, living unit representative, educational and treatment staff, youth and, if applicable Department of Children and Families (DCF) case worker. None of the youth had a support coordinator from the Agency for Persons with Disability (APD). All five youth's IPP included supporting documentation of all parties' signatures present during the treatment team meeting. All five youth records contained documentation regarding a copy of the IPP was mailed to parent/guardian and applicable DCF case workers with a request to return to the program with the signature page signed. Each youth's IPP included goals based on the top three criminogenic needs and specific delinquency interventions with measurable outcomes. All five youth's IPP and initial plans included targeted court ordered sanctions and transition activities targeted for the last sixty days of the youth's anticipated stay. All five IPPs included responsibilities of youth and staff to accomplish the goals and target dates for goal completion. The program is required to include the youth's recreation plan in the IPP. The recreation plan is included in the mental health plan (MHP) and the MHP and all treatment plan goals, addressing identified issues are documented in the IPP. 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 five 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 time frame. Five youth interviews were completed, which confirmed each participated in the development of their current performance plan and is aware of their current performance goals. All five 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. Five youth case management records were reviewed and were applicable for a ninety-day IPP revision. All five youth's IPP revision was implemented due to newly acquired/revealed information and youth's demonstrated progress toward completing a goal. Each youth's IPP was updated and completed within the required time frame. One of the five youth was found eligible for the transition phase of the program and was currently in the transitional phase in the program. The one eligible reviewed youth case management record was included to support revisions were completed on the IPP at the initiation of transition activities. These revisions were completed 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. Three youth case management records were reviewed for ninety-day performance plan summaries; one open record and two closed records. All three applicable records included a performance plan summary completed within the required time frame. Each youth's performance summary 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. Documentation in each of the youth records indicated a copy of the performance summary was provided to the youth, court, juvenile probation officer (JPO), parent/guardian, and when applicable the Department of Children and Families case worker. The original summary was filed in the youth case management record. Each performance summary was signed by all designated parties. A copy of each youth's performance summary was mailed 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 (SVPP). All three youth case management records were applicable for an updated performance plan due to release, discharge, or transfer from the program and had been completed within the required time frame. All three youth case management records were eligible for a release summary which was completed along with the Pre-Release Notification (PRN) and was sent to the JPO within the required time frame, and a signed copy maintained in each youth's case management record. Two of the three youth's record included an updated copy of a Residential Assessment for Youth (RAY) exit assessment upon approval of the PRN. The remaining youth management record was awaiting the approval of the PRN before completion of the RAY. All five interviewed youth stated they received a copy of their performance summary sent to the court.

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. Five youth case management records were reviewed. The program documented all parent/guardians and applicable Department of Children and Families (DCF) case workers attempts through mail and telephone contacts for involvement in the case management processes. A document review of all five youth case management records indicated parent/guardians and DCF case workers received an advanced notice mailed letters regarding inquires for participation in progress 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 five 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 return with signatures and a request for return back to the program. All required attendees were present for meetings.

During the annual compliance review, a formal youth treatment team meeting was observed. The meeting did not include the parent/guardian participation through the telephone. However, if the parent/guardian is unable to attend a meeting, the program provides the ability for them to give verbal and written input ahead of the meeting. An interview with the facility administrator (FA) was completed. The FA stated parent/guardian and juvenile probation officers (JPO) are contacted for participation in the meeting and the chronological notes, treatment team invites, Performance Plan Reviews (PPR) will confirm parent/guardian involvement in case management services. Five youth were interviewed, which confirmed each youth's parent/guardian and DCF case worker is involved in case management services through monthly treatment team meetings and weekly telephone 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. The members include the youth, parent/guardian, recreation therapist, juvenile probation officer (JPO), a living unit and administrative representative, mental health therapist, nurse, gang prevention specialist, transitions services manager, treatment team leader, and education. All five youth records included supporting documentation of the youth's parent/guardian, Department of Children and Families (DCF) case worker, JPO, and all meeting attendees were invited and encouraged to participate through advance notification. The program sends out invites and reminder of meeting letters to each youth parent/guardian each month. The designated meeting attendees receive email notification regarding the treatment team schedule. A review of five youth case management records supported all required members attended the treatment team meetings. During the annual compliance review, an observation of a formal treatment team meeting confirmed all members participated in the meeting. The program noted to the review team there were no youth receiving services from Agency for Person with Disabilities or applicable for trafficking-specific service providers.

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). Five youth case management records were reviewed. All five youth case management records referenced additional plans to include academics and treatment plans. Three of the five youth are in the custody of Department of Children and Families (DCF) and their care plan was referenced in each of their IPPs. The program noted to the review team 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. Five youth case management records were reviewed. Each record demonstrated meeting the time frame 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. During the annual compliance review, an observation of a youth treatment team meeting revealed all required staff were present for the observed treatment team meeting. Through the observation of a treatment team, the treatment team presented information on the progress of performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, and an opportunity to discuss demonstration of acquired skills. Youth are provided an opportunity to demonstrate new skills they have learned and discuss the progress they are making in the program. All members of the treatment team meetings were engaged and actively participated in the meeting. Interviews with five youth were completed. All five youth reported staff review their performance to include progress on performance plan goals, positive and negative behavior, and treatment progress. Each youth reported they are provided an opportunity to demonstrate skills they have learned in the program, during treatment team meetings.

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

The program has a policy and procedures to provide for career education. The program provides Type 2 career education development which includes personal accountability skills as well as completing employment applications and developing a résumé summarizing their education, work experience, and/or career training. The facility administrator confirmed the program provides Type 2 education programming to include employment applications, résumé, state issued identification, Career Source appointments, and preparation for the General Equivalency Diploma (GED) if a youth is eligible. The courses are all age appropriate and aligned with the youth's educational goals and abilities. The lead teacher indicated Florida Ready to Work is also utilized and the youth receive state certifications through this curriculum. Three closed youth case management records were reviewed and all included a completed employment application, résumé, a calendar identifying an appointment with their local Career Source Center, and documentation to support the youth's parent/guardian and juvenile probation officer were made aware of the youth's vocational plan.

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

The program has a policy and procedures to provide for educational access. The Hillsborough County Public Schools provides educational services which incorporates a 250-day calendar, spread over a twelve-month period. The district approved calendar, along with the daily class schedule, were reviewed and the six fifty-minute class periods daily provide for the minimum twenty-five hours of weekly instruction. All youth are enrolled in an academic schedule and receive credit, as appropriate through the district. An interview with the lead educator indicated the school schedule is adhered to with little to no interruptions. A review of the logbook also confirmed no interruptions to the daily school schedule. Four of the five interviewed youth indicated there were no interruptions during educational instruction. One youth revealed there were interruptions due to youth fighting or medical issues.

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

The program has a policy and procedures to provide for an educational transition plan. Three closed youth case management records were reviewed and confirmed the program's instructional staff and youth completed an education transition plan upon entry which included services and interventions based on each student's assessed educational needs and post-release education plans. The following key personnel related to transition were included in the development of the plan such as the youth, parent/guardian, education representative, post-release staff, and school district personnel responsible for providing guidance services. All three closed youth case management records included an Electronic Educational Exit Plan including information about the youth's next educational placement and a calendar with post release appointments. Five youth were interviewed and four confirmed they were involved in the development of their education transition plan. The remaining youth stated they had already completed high school; therefore, the answer was not applicable. Five youth were interviewed on how well the program prepares them for the General Equivalency Exam (GED), high school, vocational school, and/or employment. One youth stated very well, three youth stated well, and one youth stated not very well. Of the five youth interviewed, one already completed their GED and one has not yet begun their education plan due to being in quarantine.

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 in their Community Re-Entry Team (CRT) meeting and also documented their attendance. 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 each of the three records the plan was transmitted to the juvenile probation officer (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.	

Three closed records were reviewed. Each of the three closed youth records documented the exit portfolio was addressed in the exit conference, the exit portfolio was given to the youth upon release and the program forwarded the exit portfolio information to the juvenile probation officer (JPO). All 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. Two of the three exit portfolios contained a copy of the youth social security card and birth certificate. The remaining youth was unable to obtain copies of the birth certificate and social security card, prior to discharge due to the COVID-19 pandemic. Each of the three portfolios contained education records and school transcripts. All three portfolios contained résumés and a sample of job applications. All three youth 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.	

Three closed records were reviewed for an exit conference. In all three reviewed records, documentation confirmed the exit conference was held after the juvenile probation officer (JPO) notification and at least fourteen days prior to release. The 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 parent/guardian, 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. No exit conferences were observed during the week of the annual compliance review.

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

The program has a policy and procedures in place ensuring an on-going safety planning process for each youth; helping identify stimuli which have both positive and negative effects on the youth. At a minimum, the safety plan includes warning signs; youth baseline behavior, crisis recognition; debriefing preferences; intervention strategies and coping strategies, co-developed with youth which outline people and healthy environments defined by youth. The program maintains a safety plan binder which is located in master control and is easily accessible to all staff. The binder contains safety plans for each youth in the program and is updated every thirty days for each youth. Also, a safety plan is stored in the individual mental health record of each youth in the program. Five youth mental health records were reviewed. Each youth mental record contained a current safety plan. Each safety plan was completed within fourteen days of the youth admission and was jointly developed by the youth, parent/guardian, program clinical staff and behavior specialist, if applicable. All five safety plans incorporated any recommendations from previous or current clinical assessments, incorporated trauma responsive practices, and are reviewed by staff who have contact with youth. All five interviewed youth stated they were involved in the development of their safety plan. All five interviewed staff stated the location of the safety plan binder is in master control and they were knowledgeable of the process for reviewing safety plans.

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 designated mental health clinician authority (DMHCA) has an active license as a licensed mental health counselor (LMHC) in the State of Florida under Chapter 491. LMHC license is currently active with a reflected expiration date of March 31, 2021. The DMHCA holds the position title of clinical director and is on-site, at minimum, forty hours a week with on-call status twenty-four hours a day, seven days a week for any identified clinical consult needs, which meets contractual requirements. Exception occurs when the program utilizes a licensed clinical staff to provide on-call emergency and after hour services for mental health or substance abuse emergencies. The program has on staff, an assistant clinical director who provides direct support to the clinical director in the DMHCA role. The assistant director holds an active Florida mental health counselor license which expires on March 31, 2021. The responsibilities of the DMHCA were outlined in the duties contained within the clinical director's job description. During an informal interview, the DMHCA was able to articulate the process for screening, assessments, evaluation, treatment planning, and response to mental health and/or substance use emergencies. The DMHCA provides direct weekly supervision to all non-licensed clinicians providing services to the youth. During supervision, the DMHCA reviews a sample of treatment records, provides support, assists, and directs service provision for each of the non-licensed mental health professionals. The DMHCA also provides clinical services to youth as well as in-service training to the therapeutic team and direct care staff on mental health and substance abuse related topics throughout the year.

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 facility administrator and designated mental health clinician authority (DMHCA) ensure mental health and substance abuse treatment services are provided by individuals who meet the required qualifications. The DMHCA further ensures those delivering clinical services receive weekly supervision and meet the educational, training, and field experience requirements. At time of the annual compliance review, there were two licensed mental health counselors, a Florida certified behavioral analyst (CBA), and a contracted licensed school psychologist as required by contract. All mental health counselor licenses were posted in a program area viewable by youth and reviewed and verified to be active with an expiration date

of March 31, 2021. The school psychologist license was posted in a program area viewable by youth and is valid through November 30, 2021. Two master's-level clinicians are Florida registered mental health counselor interns with one registration expiring on March 31, 2022 and the other expiring on June 7, 2022 in which both are working towards their licensure.

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 facility administrator is responsible for ensuring mental health and substance abuse treatment services are provided by individuals with appropriate qualifications and training. The designated mental health clinician authority (DMHCA) ensures clinical staff working under supervision are performing services they are qualified to provide based on education, training, and experience. The program has five non-licensed clinical staff, all under the direct supervision of the DMHCA. All non-licensed clinicians hold a master's-level degree in social work, mental health counseling, or counseling education. Four of the five non-licensed clinicians completed the required training and observations in order to assess suicide risk. The fifth staff is currently working on completing this training. Review of documentation confirmed each non-licensed clinical staff completed the education and training specified in Rule 63N, F.S. 397 and in the program's contract. The program holds an active Department of Children and Families (DCF) Chapter 397 license which allows for the provision of substance use treatment services by non-licensed clinicians. The program's 397 license is posted in the program's lobby and is valid through April 7, 2021. A review of supervision logs for the prior six months documented weekly supervision for all non-licensed mental health and substance abuse treatment staff for at least an hour. All clinicians received a weekly supervision for the week's treatment services were provided. Training and supervision provided by the clinical director to the non-licensed therapists was documented and maintained in the supervision binder.

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's comprehensive mental health and substance abuse plan outlines implementation of a standardized admission/intake mental health and substance abuse screening process. Five youth records were reviewed for mental health and substance abuse admission screening. The program utilizes the Massachusetts Youth Screening Instrument- Second Version (MAYSI-2) to screen all youth upon admission to the program for mental health, substance abuse, and/or risk of suicide. All five screenings indicated a need for further assessment with three of five requiring the completion of an Assessment of Suicide Risk (ASR). Due to all youth being identified as needing intensive mental health treatment services, an Assessment of Suicide Risk (ASR) is completed on all youth to further determine the suicidal risk level of youth during the admission screening process. The program also conducts screenings using the Vulnerability to Sexually Aggressive Behavior (VSAB) instrument, "You Have the Right to be Safe from Sexual Violence", University of Rhode Island Change Assessment Scale (URICA), Simple Screening Instrument for Alcohol and Other Drug Abuse (SSI-AOD), and an ASR on each youth at admission. These

additional screening instruments assist in identifying treatment needs of the youth. The screening process is conducted by licensed and non-licensed clinicians. As part of the screening process there is a thorough review of any prior assessments and comprehensive evaluations. A record review document is completed prior to youth intake and verifies review of the most recent comprehensive evaluation, youth face-sheet including alerts, commitment packet, and the prior Community Assessment Tool (CAT). Youth interviews are conducted face-to-face and parent/guardian history is obtained by telephone, when possible. All five reviewed youth records contained the completed screening instruments. Two of the five records reviewed did not have the "service response" box correctly indicated on the MAYSI-2; however, the delivery of needed assessment and evaluation was not impeded by this exception. All five records had a completed Mental Health/Substance Abuse Treatment Screening and Referral document accurately aligned with the needs identified through screening. Program staff noted any existing documentation of mental health and/or substance abuse problem, needs, risk factors, and history of human trafficking (Endangered Person JJIS Alert). Screening report was provided to clinical and administrative staff. Training documents were provided and indicated clinical staff were trained on accurate completion of screening tools. All screening instruments were signed by the clinician who completed the admission screening and were reviewed by a licensed clinician, if a non-licensed clinician completed the screening and referral document. An interview with the program director confirmed the program completed a MAYSI-2, ASR, and VASB as part of their screening process to identify youth at risk for suicide, mental health problems, and substance abuse problems.

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 to address identified needs for further assessment of mental health/substance abuse services for admitted youth. All five reviewed records included a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) which indicated a need for further assessment upon admission to the program. The program's procedures involve a completed screening and referral summary for a mental health and substance abuse evaluation on the date of admission. The evaluation process for each youth entails a comprehensive bio-psychosocial mental health/substance abuse evaluation and was completed by a mental health clinician within thirty days of a youth's admission into the program. Four of the five records contained a "new" bio-psychosocial mental health/substance abuse evaluation completed in entirety, containing all required components as outlined in Florida Administrative Code 63N-1. 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. One youth transferred from a True Core operated residential program and the evaluation completed six months prior to admission to the current program was utilized. No new evaluation or update was completed. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter

397 to provide substance abuse treatment services. All five reviewed records contained a signed consent for substance abuse services. Two of the five evaluations reviewed were completed by a non-licensed clinician and were subsequently reviewed by the licensed clinical director within three days of completion. One of the five youth was identified to need further psycho-sexual evaluation. The youth was referred and a psycho-sexual evaluation was completed within thirty days of referral. All five youth received an initial diagnostic evaluation by the psychiatrist within the first fourteen days of admission. The psychiatrist documented the evaluation using the required Clinical Psychotropic Progress Note (CPPN). All five records reviewed had an Initial Treatment Plan (ITP) completed on the day of admission by a licensed clinician or a non-licensed clinician, with a subsequent review by the licensed clinician within three days of development and included a goal for the completion of a comprehensive mental health/substance abuse evaluation.

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

The program has a policy and procedures to offer a comprehensive plan for mental health and substance abuse treatment services to admitted youth. All mental health and substance abuse treatment services are provided by a licensed mental health clinician or non-licensed master's-level clinician working under the direct supervision of a licensed professional. All records indicated upon admission, each youth was assigned to a multidisciplinary treatment team, which included the youth, parent/guardian, administration, education representative, medical, mental health clinician, and dormitory representative. During the annual compliance review, one treatment team meeting was observed with all required parties present or invited to participate. Documentation supports the program makes a telephone contact attempt to the youth's juvenile probation officer (JPO) and parent/guardian to participate in treatment team meetings. All five records enclosed a current, signed, and dated Authority for Evaluation and Treatment form. All five reviewed records had signed Substance Abuse Consent and Release forms. Group therapy for mental health is limited to ten or fewer youth and group therapy for substance abuse is limited to fifteen or fewer. Observation of group was not conducted during the annual compliance review in order to practice social distancing due to the current COVID-19 pandemic. A review of progress notes of the past six months verified mental health and substance abuse groups occurred as scheduled and did not exceed the appropriate number of allowed youth. Staff interviews reflected all mental health and substance health groups are provided as scheduled for the youth daily. An interview with the designated mental health clinician authority (DMHCA) confirmed the program's service provision of individual, group, and family therapy to the youth is in accordance to their treatment plan. Interviews with five youth confirmed the youth reported participation in individual and group therapy. Clinical groups conducted at the program include Voices; Thinking, Feeling, and Behaving; Dialectical Behavior Therapy (DBT) Skills Training; Conflict Resolution and Teen Relationships. In addition, direct supervision of mental health clinicians includes conducting fidelity checks on group and individual sessions and a documentation review of all services being provided.

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.*	

Treatment needs are identified through the culmination of information gathered through previous medical and mental health records, current assessments and evaluations, youth and parent/guardian interviews, and staff observations. Recommendations made through past comprehensive evaluations are considered and incorporated in the youth's mental health and/or substance abuse treatment plan. All five youth records contained the Department's Initial Mental Health/Substance Abuse Treatment Plan (ITP) which was developed on the day of admission, which exceeds requirement. ITP records were completed by a licensed clinician or a non-licensed clinician with the signature of a licensed clinician review less than ten days from development of the plan. The youth and all treatment team members signed the Initial Mental Health/Substance Abuse Treatment Plan. Copies of the plan were documented as provided to the youth and parent/guardian. All five youth had a Multidisciplinary Individualized Treatment Plan (MTP) completed within thirty days of admission and contained individualized goals, objectives, and projected time frames for completion. The plans also identified responsible parties for each goal and objective. There was documentation to reflect the parent/guardian provided valuable input into the treatment decision making process, as well as documented telephonic attempts and/or participation of the juvenile probation officer (JPO). MTP records were completed by a licensed clinician or a non-licensed clinician with the signature of a licensed clinician review less than ten days from development of the plan. All five records had treatment plan reviews every thirty days post completion of the MTP. Treatment reviews were recorded on the Department's Mental Health/Substance Abuse Treatment Plan Review (TPR) record and were signed by a licensed clinician or non-licensed clinician with the signature of a licensed clinician review less than ten days from the date of the treatment plan review. All five mental health records contained weekly progress reports for the daily treatment related services provided for each youth. The services were consistent with the treatment recommendations identified through the youth's assessment process and treatment planning. Youth are provided individual sessions weekly, family sessions, if indicated at least monthly, daily groups, psychiatric and medication management, as applicable. Three closed mental health and substance abuse youth records were reviewed for the mental health/substance abuse treatment discharge summary. All records contained a discharge summary recorded on a Department form, Mental Health/Substance Abuse Treatment Discharge Plan form, with documentation verifying the discharge plan was discussed during the youth's exit conference. None of the youth were released on a suicide risk or precautions; therefore, no notifications to the parent/guardians or juvenile probation officers (JPO) were required. Documentation in each youth's record noted the parent/guardian and juvenile probation officer (JPO) received a copy of the discharge summary.

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

The program has a policy and procedures to address the provision of specialized treatment services for the youth. The program provides intensive mental health treatment services with inclusion of substance abuse treatment services, when applicable, borderline developmental services and intensive medical overlay care. Intensive mental health services are defined in the program's comprehensive plan for mental health and substance abuse services plan as youth diagnosed with a diagnostic statistical manual- five (DSM-5) disorder who demonstrates serious symptoms of the disorder and impairment in social, emotional, and/or adaptive functioning of substantial degree and duration. The functional impairment is expected to continue for at least six months and not a temporary response to a stressful situation. The facility administrator reported the program mainly provides intensive mental health services as a means for specialized treatment services. Each admitted youth participates in the development of an individualized mental health and/or substance abuse treatment plan. The treatment plans outline services for individual, group, and family therapy. The program offers each youth, at minimum, weekly individual therapy and group therapy seven days a week for fifty minutes. In addition, applicable family therapy sessions are provided monthly. The program has mental health clinical staff readily available, as needed, for supportive counseling, therapy, and crisis interventions. An on-site recreational therapist is also available to provide as-needed therapeutic activities for the youth. Each mental health clinician does not exceed a caseload of twelve youth as required in program's contract. There is at least one mental health clinician available on-site seven days a week. The designated mental health clinician authority (DMHCA) which is a licensed mental health clinician, is on-site five days a week for a minimum of forty hours. A review of group progress notes and group sign-in documentation confirmed clinical staff were at the program seven days a week. The program also includes a full time certified behavioral analyst. The contracted psychiatrist is on-site one day a week to perform psychiatric evaluations and to conduct medication management visits, as needed, and is available twenty-four hours a day, seven days a week for consult. 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.

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 written policy and procedures to address the provision of psychiatric services to the youth. The program has a contract with a licensed psychiatrist who provides psychiatric services to the youth in the program. The services provided include an initial psychiatric evaluation, follow-up evaluation referrals, medication management, treatment planning, and supervision of treatment for youth prescribed medications. The psychiatrist is on-site once a week, as required by contract, and is available for psychiatric emergencies and by telephone twenty-four hours a day, seven days a week. The program's procedures include

youth must be referred within fourteen days of admission to the psychiatrist for an evaluation. Five youth mental health and substance abuse records were reviewed. Each record contained a timely completed referral and psychiatric evaluation; all of which were documented on a clinical psychotropic progress note (CPPN). The form was clearly identified as a psychiatric evaluation. All five psychiatric evaluations were completed with the required elements including history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders diagnosis, and treatment recommendations. Two of the five youth were admitted to the program with prescribed psychotropic medications with one youth placed on psychotropic medication post admission. The psychiatric evaluations for each youth taking psychotropic medications included a discussion on the required elements, prescribed medication, an explanation for the need of the medication, and the frequency of medication management. The program sent written parental notifications as required, for all medical interventions. When medications were prescribed or altered, the program made telephonic contact attempts to the youth's parent/guardian in order to receive consent. All applicable youth's parent/guardians provided verbal and written consent for medications. Three youth was jointly served by the Department and the Department of Children and Families. All records contained the required consent for the provision of psychotropic medications. A review of the last six months of records and psychiatric progress notes verified the psychiatrist consistently conducted follow-up visits every thirty days for medication management on applicable youth. An interview with the psychiatrist revealed, the psychiatrist is on-site once weekly and on-call seven days a week, twenty-four hours a day. The role of the psychiatrist at the program is to provide psychiatric information to a member of the treatment team and provide feedback to incorporate into the youth's treatment plan. In addition, to being primarily responsible for the prescriptions and monitoring of the youth medication in the program. The program also maintains an agreement with a healthcare agency which provides psychiatric coverage for the contracted psychiatrist when unavailable. A review of sign-in sheets for the annual compliance review period of the last twenty-six weeks confirmed on-site visits were met. A review was completed of the psychiatrist credentials, which confirmed the license is current and active in the State of Florida. The psychiatrist's license expires on January 31, 2021.

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 which is part of a comprehensive plan for mental health and substance abuse services, crisis intervention, suicide prevention, and emergency care. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral process, communication, notification, documentation, immediate staff response, and a review process. The plan was signed on November 24, 2019 by the facility administration (FA) and the designated mental health clinical authority (DMHCA) on February 1, 2020. A review of ten staff pre-service and in-service training records contained documentation supporting each staff member received, at minimum, the required six hours of annual training in suicide prevention. Mock suicide drills were documented and occurred quarterly across all shifts in the program.

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 which was approved by the facility administrator (FA) and designated clinical mental health authority (DMHCA) on February 1, 2020 and outlines the procedure for addressing suicide prevention services and a review of any serious suicide attempt or critical self-inflicted injury resulting in hospitalization or medical attention. The program has a suicide response kit located in master control and contained a knife for life, needle nose plier, and a wire cutter. The program vans contained a knife for life and seat belt cutter. Five staff were interviewed and reported they were aware of the location of the knife for life kit and supplies maintained on program vehicles. Policy and practice indicate the administration of an Assessment of Suicide Risk (ASR) is conducted on all youth on the day of admission, regardless of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) results. Recommendations for elevated supervision or discontinuance is only completed upon the face-to-face interview and assessment of the youth with recommendations documented. The program completes a restrictions checklist for youth placed on precautionary observation, secure observation, and/or mental health alert status. The checklist includes the level of supervision, and restrictions such as designated safe housing area, youth to be searched, the clothes the youth is permitted to wear, items youth is permitted to have, and the activities the youth is permitted to participate in. The checklist is signed by a licensed clinician and the FA or designee. The program utilizes the Department's ASR form to complete each ASR. Five youth mental health and substance abuse records were reviewed for verification of program practice. Three of the five youth required further suicide risk assessment based on the MAYSI-2 for being at risk for suicide with the remaining two youth assessed were based on the procedures outlined in the Suicide Prevention Plan. All records contained a completed ASR on the day of admission with all maintaining standard supervision post ASR completion. Three of the five ASRs were completed by the licensed mental health clinician and the remaining two were conducted by a non-licensed mental health clinician. The two assessments completed by non-licensed staff documented consult with the clinical director who later signed the assessment within the required time frame. A review of the non-licensed clinical staff training confirmed they received all required suicide assessment training outlined in Rule 65N. During their stay, three of the five youth in the sample reviewed made gestures or threats of self-harm post admission and were immediately referred for an assessment of suicide risk and placed on an elevated level of supervision. All referred assessment of suicide risks were completed on the same day for all three youth. The youth who were continued on precautionary observation as a result of the ASR were stepped down to close supervision when deemed appropriate by a clinician using the follow up ASR form. While placed on precautionary observation, the youth were permitted to participate in limited activities and were not limited to their sleeping room. Precautions include direction for supervision, observation, monitoring, and housing for youth placed on suicide precaution. There was a restrictions checklist completed each time a youth was placed on precautionary observation. A follow-up ASR was completed every twenty-four hours until the

youth was placed on close supervision; each follow-up ASR was completed, as required. The youth's parent/guardian and juvenile probation officer were notified of each placement on precautionary observation. Each youth had a mental status exam completed prior to removal from close supervision. The documentation also reflected a conference with a licensed clinician and the FA/designee prior to reducing the level of supervision. Two of the three youth were moved to secure observation (SO) status by staff with one youth being placed in secure observation on two occasions. All required notifications were completed and approvals were documented by the FA and the designated mental health authority. ASR were all completed on the same day of secure observation placement. A review of the secure observation log sheet indicated the youth were released from secure observation on the same day and remained on constant observation. All three secure observation placements examples provided for review contained documentation of staff completion of a Health Status Checklist, search of the youth, and inspection of the room. The logs were completed as required, documenting safe housing areas. There were no lapses noted on the reviewed observation logs. All of the logs were reviewed and signed by the shift supervisors and the licensed mental health clinician. A logbook review for dates the youth were placed on precautionary observation and/or secure observation included the time youth were placed on precautions, the time youth placed on close supervision, and the time youth returned to standard supervision. A review of the Department's Juvenile Justice Information System (JJIS) revealed all alerts were opened and closed, as required. Five interviewed staff were aware of the suicide response kit's location and program's procedures in an event where a youth expresses suicidal thoughts.

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

The program utilizes the required Suicide Precautions Observation Logs when a youth is placed on suicide precautions. The program maintains Suicide Precaution Observation Logs on youth who have been placed on constant supervision, one-to-one, or close supervision. A review of completed precautionary observation logs indicated the logs were completed with direct care and clinical staff documenting observed youth behaviors in accordance with Florida Administrative Code 63N-1.00951. Review of Suicide Precaution Observation Logs supported documented observations were recorded, as required, for youth placed on constant, one to one, and close supervision. The Suicide Precautions Observation Logs were reviewed and signed by the appropriate shift supervisor and qualified mental health clinical staff member. A review of five youth records found three of the youth were placed on suicide precautions which required completion of precautionary logs. All twenty-five observation logs reviewed met all requirements. The logs were completed as required, documenting safe housing areas. There were no time lapses noted on the reviewed observation logs. All logs were maintained for the duration the youth was on suicide precautions, and staff documented youth behavior in real time at intervals which did not exceed the timeline requirement of thirty minutes for constant supervision and five minutes for close supervision. Warning signs were reflected on the initial log and summarized reason for placement with subsequent warning signs reflected as identified during the period the youth was maintained on an elevated level of supervision. Logs documented notification to facility administrator and designated mental health clinician authority (DMHCA). A review of the secure observation log sheets indicated the youth were released from secure observation on the same day and remained on constant observation. All precautionary logs were reviewed and signed by the shift supervisors and the licensed mental

health clinician daily. Three youth previously placed on secure observation or precautionary observation status were interviewed. Each confirmed they were never left alone while on observation and staff was always present.

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

The program has a suicide prevention plan last approved by the facility administrator (FA) and designated clinical mental health authority (DMHCA) on February 1, 2020 and outlines the requirement for suicide prevention training. A review of ten staff pre-service and in-service training records contained documentation supporting each staff member received, at minimum, the required six hours of annual training in suicide prevention. Mock suicide drills were documented and occurred monthly across all shifts in the program. The drills for the previous year were reviewed. Each drill included the time of the drill, the designated shift, name of the staff who conducted the drill, the nature of the incident, person(s) involved, type of medical care provided, when applicable, type of mental health/crisis intervention provided, the outcome of the incident, time of response, and any follow up or corrective action needed. The mock drill training documentation supported staff participated in drills, as required. The FA interview confirmed the program conducts monthly mock suicide drills on all shifts. Five staff were interviewed to confirm how often monthly mock suicide drills are conducted. Two of the five staff stated mock suicide drills are conducted monthly, one staff stated they are conducted once every two weeks, one staff stated once every one-to-two weeks, and once staff stated they were conducted weekly.

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 last approved by the facility administrator and designated clinical mental health authority (DMHCA) on February 1, 2020 and outlines the policy and procedures for responding to youth in crisis in the least restrictive method possible without compromising the safety of the youth in crisis and others. The plan includes a notification and alert system, means of referral including youth self-referral, communication, supervision, and documentation and review of the crisis.

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

The program utilizes Crisis Assessment interventions when a youth's psychological distress was not associated with a suicide risk factor according to program policy which aligns with Florida Administrative Code 65N. The program utilizes the Department's Crisis Assessment which addresses the reason for assessment, mental health status exam, determination of danger to self and others, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notification to parent/guardian of follow-up treatment. One of the five reviewed youth records required the completion of a crisis assessment. Two additional Crisis Assessment youth records were provided for review. In each instance, the Crisis Assessment was completed within two hours of identified need. Crisis Assessments were completed within two hours of referral by a master's-level clinician and signed by the designated mental health clinician authority (DMHCA) on the same day the crisis assessment was completed. Crisis Assessments were completed in entirety and contained all the required elements. One of the three youth were applicable for placement on mental health alert status post completion of the Crisis Assessment. All required notifications were completed in a timely manner for the youth who was placed on constant supervision post completion of the Crisis Assessment. This youth was maintained on a mental health alert and constant supervision until completion of a mental status exam lowered the level of supervision to standard. Review of the Department's Juvenile Justice Information System (JJIS) supports documented alert placement and includes placement on elevated supervision and removal and return to standard supervision. Logbook reflects youth's placement on mental health alert and constant supervision and return to standard supervision.

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

The program has a written emergency mental health and substance abuse services plan which is part of a comprehensive plan for mental health and substance abuse services, crisis intervention, suicide prevention, and emergency mental health/substance abuse care and contained all the requirements outlined in Florida Administrative Code. The program has policy and procedures outlining a written plan to utilize for emergency incidents due to mental health and substance abuse. The program's emergency mental health and substance abuse services plan contained immediate staff response, notifications, communication, supervision levels, authorization to transport to emergency mental health and/or substance abuse services, transport for Baker and Marchman Act, documentation, staff training, and a review process.

Procedures were organized and outlined in great clarity. The plan was reviewed and signed by both the facility administrator on September 9, 2019 and designated mental health clinician authority (DMHCA) on February 1, 2020.

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

The program has an emergency care plan last approved by the facility administrator (FA) on November 24, 2019 and designated clinical mental health authority (DMHCA) on February 1, 2020 and establishes the method in which all youth who present as an imminent danger to self because of mental illness or substance abuse impairment shall receive appropriate emergency treatment, including the provision of the Baker or Marchman Act. The program reported an absence of a Marchman Act and one Baker Act occurrence since the last annual compliance review. The program demonstrated a practice supporting any youth identified to be an imminent danger to themselves or others were referred, assessed and transported for Baker Act according to policy which aligns with Florida Administrative Code. One youth resulted in a Baker Act due to self-inflicted harm. The youth injury was medically treated and then transported to involuntary commitment. Due to nature of the injury, time did not allow for documenting the elevated level of supervision or a completion of an Assessment of Suicide Risk (ASR) and involuntary commitment paperwork. Prior to discharge from the crisis stabilization center, a discharge summary was requested and reviewed by the designated mental health clinician authority (DMHCA). Immediate upon the youth's return to the program, the youth was maintained on constant supervision and an ASR was completed by a licensed clinician with a step down to close supervision recommended post assessment. Precautionary observations logs were reviewed and complied with all Florida Administrative Code 65N-1 requirements. A follow up assessment of suicide risk and two mental status exams were completed prior to the youth's return to standard supervision and were adjusted collaboratively between the FA, qualified mental health professional, and the designated mental health clinician authority (DMHCA). With review of the Department's Juvenile Justice Information System (JJIS), alerts were accurately reflected and created and ended according to requirement. A review of the logbook supported applicable youth having a documented log notation for transport to medical facility and involuntary commitment with the return to facility post crisis stabilization discharge recorded as well as the corresponding levels of supervision until the youth was removed from suicide precautions. The reviewed documentation supported the emergency care plan was followed.

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.	

Documentation confirmed the designated health authority (DHA) is a licensed internal medicine physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. The program has a contract with a licensed physician who holds an unrestricted license in the State of Florida with an expiration date of January 31, 2021 and had specialty training in internal medicine. The DHA is on-site at least once a week, with a week defined as the seven-day period beginning on Sunday and ending on Saturday. Documentation revealed for the previous six months, the DHA was on-site five hours a week in accordance with the program's contract. If the DHA is on vacation or a scheduled absence, coverage is arranged with another doctor of equal licensure. Since the last annual compliance review, the backup doctor's services were not needed. The DHA is responsible for regarding youth medical needs, acute medical concerns, emergency care, and coordination of off-site care.

The DHA interview indicated their role at the program is to complete Comprehensive Physical Assessments (CPA) within seven days of admission, complete periodic evaluations, conduct sick calls requiring follow up, involved in policy and procedure development, and provide on-call services twenty-four hours a day seven days a week, including holidays.

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

Documentation confirmed the designated health authority (DHA) and facility administrator have signed and dated all respective treatment protocols and medical facility operating procedures (FOPs) on June 17, 2020. Nursing staff signed and dated a cover page on which all medical FOPs, treatment protocols, and other procedures are listed. New policies or changes in polices are reviewed, signed, and dated by each nurse on the individual policy when changes occurred on August 3, 2020. A review of orientation documentation for new healthcare staff was conducted. Since the last annual compliance review, two new medical staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures, which is given by a registered nurse. Approval of treatment protocols or standing procedures were written and authorized by the DHA and were not delegated to any other person. The review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management is only performed by the program's psychiatrist. The psychiatrist reviewed and signed FOPs related to psychiatric services and psychotropic medication management.

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 to address parent/guardian consent which requires a signed Authority for Evaluation and Treatment (AET) by the youth's parent/guardian.

Five youth individual healthcare records (IHCRs) were reviewed and two records contained a legible copy of the AET with the word "copy" stamped on the form. Three youth were co-served by the Department of Children and Families (DCF) and the Department. The parental rights of two out of the three youth had been terminated. The third youth entered the program and the parent/guardian signed the AET; however, the youth was later placed in the custody of DCF. All three DCF youth had a court order allowing for the provisions of routine medical care. All consents remained valid because the youth remained in the custody of the Department since the document was signed. Two youth turned eighteen years of age while in the program and the medical staff had the youth sign a consent for youth eighteen years or older.

The nursing staff interview indicated, the program's policy for obtaining a new or current AET, is to send a request for signature to the parent/guardian or the juvenile probation officer (JPO) to receive medical treatment. For youth who are eighteen years of age or older, the program has a consent for the youth to sign.

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

The program has a policy and procedures to address parental notification. The policy requires notification to the youth's parent/guardian for any new medications, off-site referrals, and medical emergencies. The policy also requires additional informed consent for special circumstances such as hospitalizations, surgeries, or other invasive procedures. The program maintains a list of over-the-counter (OTC) medications which were approved by the designated health authority (DHA). The list is sent to all parent/guardians with instructions to sign and return the form to the program which provides their consent for the medications.

Five youth individual healthcare records (IHCRs) were reviewed for parental notifications including OTC medications and vaccinations/immunizations not consented for on the Authority for Evaluation and Treatment (AET), significant changes to existing medications, off-site emergency care and medical treatment, and discontinuation of medication prescribed prior to youth entering the custody of the Department, and for new medications. Two youth had written notifications sent to their parent/guardian and the three Department of Children and Families (DCF) youth had written notifications sent to the DCF caseworker. A review of documented practice supported written notification was sent to the parent/guardian regardless of telephone notifications. For all telephone notifications, a second staff member witnessed all telephone call attempts and conversations. Each applicable record contained documentation of the program obtaining consent prior to administering psychotropic medications.

Two of the five youth were applicable for off-site care. The documentation supported parental notification was made for all off-site care. None of the five youth were applicable for receiving off-site emergency care, as a result, three additional youth were provided. All three youth had

parental notification conducted by telephone and later in writing when they received off-site emergency care.

Two youth psychotropic medication drug dosage was changed and parent/guardian verbal consent was documented on page three of the Clinical Psychotropic Progress Note (CPPN), as well as written consent documented on the Acknowledgment of Receipt of the CPPN. In four of the five IHCRs, the vaccinations were verified within thirty days of the youth's admission. One youth vaccination was a transfer from another residential facility whose vaccination was not reviewed upon admission into Lake Academy. There were no youth applicable regarding religious or medical exemption.

The nursing staff interview indicated immunizations are obtained from the Department's Juvenile Justice Information System (JJIS) or Florida Shots and reviewed during the admission process.

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

The program has a policy and procedures addressing healthcare admission screening which requires the completion of a Facility Entry Physical Health Screening (FEPHS). The policy requires the FEPHS to be completed by a nurse on the youth's date of admission to the program. All five reviewed youth individual healthcare records (IHCRs) contained a FEPHS form completed on the date of admission by a registered nurse (RN). In one IHCR, the youth had a change in physical custody while in the program. When the youth returned to the program, a new FEPHS was completed by an RN on the date the youth returned to the program. All five youth's Chronological Progress Notes received consent to conduct pregnancy screening and contained the results. An interview with the RN confirmed the practice for completing FEHPS forms at admission and re-admission to the program.

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

The program has a policy and procedures to address the provisions of healthcare orientation to the youth. The program has a comprehensive orientation to their medical services. The orientation is provided by a nurse on the day of the youth's admission to the program. The provision of the orientation is documented by the signature of the youth and the nurse providing the orientation on the orientation form.

All five reviewed youth individual healthcare records (IHCRs) confirmed all five youth received a general care orientation upon admission to the program which included the topics of access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process to include side effects monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers. All of the orientation topics were documented on the Department's form for healthcare education. A review of the posted healthcare contacts confirmed the list was accurate with the healthcare staff information.

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 requires notification to the designated health authority (DHA) upon the youth's admission to the program, regardless of the youth's medical condition. The program has a computer system which all healthcare progress notes are completed, including the admission notes. The following information is documented on the program's nursing chronological admission note such as the youth's name, vital signs, allergies, medical grade, the date the youth's Comprehensive Physical Assessment (CPA) is scheduled, whether the youth's immunization record was received and reviewed, any medication the youth is admitted with, whether the youth is pregnant, date pregnancy test was completed, date the purified protein derivative (PPD) was taken, and whether the youth was offered an human immunodeficiency virus (HIV) test. The nurse's review of the youth's medical record and the Department's Juvenile Justice Information System (JJIS) are also documented on the admission progress note. Following the completion of the admission progress note, the nurse conducting the intake notified the DHA for all youth and psychiatrist for youth who entered the program with psychotropic medication. Each contact was made by telephone and was documented by the nurse on the program's DHA and Psychiatrist Notification of Admission form as well as on the Admission Chronological Progress Note. The notification included the youth's name, date of birth, medical grade, medications, history and current allergies, and chronic conditions. The form is signed and dated by the nurse completing the form and signed by the DHA on the DHAs next visit to the program.

Five youth individual healthcare records (IHCRs) were reviewed and four were applicable regarding admission with a known or suspected chronic condition. All four youth were admitted with a known chronic condition and there was evidence in the IHCR a referral was made to the DHA telephonically and documented on the chronic condition log. None of the youth admitted to the program required an emergency response or notification to the DHA.

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

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

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

The program has a policy and procedures which outlines the requirements for completing the Comprehensive Physical Assessment (CPA) for all youth admitted into the program. Five youth individual healthcare records (IHCRs) were reviewed. In all five IHCRs, the program utilized the Department's CPA form. In all five IHCRs, the CPA was completed within the first seven days of the youth's admission by the designated health authority (DHA) and the medical grade was documented on the form. All five CPAs were completed in accordance with the Department's rule requirements and all sections were marked with an "O" or an "X". Any section of the exam which was refused was marked appropriately and "youth refused" was documented with the youth's signature next to the statement. The Department's Problem List was updated, if necessary.

The program has a policy and procedures to address the completion of tuberculosis screening which requires a Tier 1 screening for tuberculosis to be completed during the completion of the Facility Entry Physical Health Screening (FEPHS). All five youth IHCRs included documentation to support a Tuberculin Skin Test (TST) was completed within the last year and the results was recorded on the CPA and Infectious and Communicable Disease (ICD) form. The youth were assessed prior to placement in the general population. None of the youth required further testing or procedures. Reviewed documentation validated the Department's Problem List was updated for each youth throughout their stay, when applicable. During an interview, the health service administrator confirmed the CPA form is completed within seven days by the DHA and each youth is screened for tuberculosis at admission.

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 to address sexually transmitted infection (STI) screening which requires the screening of all youth upon admission to the program. There is a standing admission order from the designated health authority (DHA) which requires the nurse completing the admission process to clinically screen the youth. The screening is to be completed utilizing the Department's screening form. The DHA will review each completed STI screening form to determine whether the youth requires testing. There is a standing order/protocol to be used for STI testing. The testing is to be completed with results documented and any required treatment started for the youth.

All five reviewed youth individual healthcare records (IHCRs) contained a completed screening and evaluation for sexually transmitted infections (STIs). All five youth received testing on the date of admission and the results were documented on the Infectious and Communicable Disease (ICD) form, excluding the human immunodeficiency virus (HIV) results. The referrals as well as the testing were documented on the STI form and/or the progress notes. In all five IHCRs, the youth was offered HIV counseling and testing but only four youth consented and received the HIV test. Consent was maintained in the IHCR. The HIV test results were filed in a confidential manner consistent with the Florida Statute in a sealed envelope marked "Confidential" and were not included in the program's internal alerts. The HIV counseling and testing was provided by an outside vendor who has the500/501 certification from the

Department of Health (DOH). In the event of a positive case, the counseling service contacts the DHA directly. Five youth were interviewed and each indicated they could request a 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 which outlines the provision of sick call to include procedures for when licensed healthcare staff are not on-site. Five youth individual healthcare records (IHCRs) were reviewed and none of the youth were presented with similar sick call complaints three or more times within a two-week period or complained of any severe pain with which the staff was unfamiliar. All five youth completed Sick Call Request forms which were placed in a locked box and retrieved by the nursing staff. In five IHCRs, the nurse completed the Sick Call Request form and each were filed with the progress notes in the IHCR in reverse chronological order. Documentation supported the registered nurse (RN) completed the sick call with the youth within twenty-four hours of the youth submitting the sick call. None of the youth were placed in restricted housing.

In all five IHCRs, the Sick Call Request Form or progress notes were documented in accordance with the Health Services Rule and each sick call was also documented on the Sick Call Index and the Sick Call Referral Log. The program conducts sick call daily as indicated in the contract and the hours are posted in each of the youth's modules. Sick call is conducted by a licensed nurse. One sick call was observed with the verbal consent of the youth. The youth was escorted by a youth care supervisor to the clinic where the youth sat on the exam table. The supervisor remained outside of the exam room to maintain confidentiality. There were no other youth present. The nurse indicated the reason why the youth was being seen as it was written on the Sick Call Request Form and began to question and examine the youth, including taking the youth's vitals. After the examination was concluded, the youth was given a follow-up plan, and a Sick Call Request form to sign. Five staff were interviewed and each indicated the nurse conducts sick call. Five interviewed youth indicated they can see a nurse within one day of requesting sick call.

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

The program has a policy and procedures to address episodic and first aid care for the youth. The program developed a roster to document youth requiring episodic care or first aid treatment. Five youth individual healthcare records (IHCRs) were reviewed and three youth required on-site first aid or episodic care. The three youth received on-site care by a licensed healthcare staff which was documented in problem oriented subjective, observation, assessment, and plan (SOAP) or standard narrative charting. The events were documented on the Episodic Care Log. The emergency numbers were posted within the clinic in the nurse's office which is inaccessible to the youth. There are seven first aid kits and all are maintained in master control which is centrally located to the three dorms and classrooms. There are no designated first aid kits used for transports. The transport staff select a kit from the locked

drawer in master control prior to a transport. The designated health authority (DHA) approved the items placed in the first aid kits. During the annual compliance review, the contents of three first aid kits were observed. Each kit was sealed and stocked with approved contents. There were no expired items in any of the three reviewed kits. When an item is used in a first aid kit, the item is taken to the medical clinic for replenishment. There was documentation to support a nurse completed a weekly check of each first aid kit for the past six months. The weekly checks were documented on the emergency equipment inspection log. The program has two suicide response kits and each includes a knife-for-life, needle nose pliers, and wire cutters. The suicide response kits are reviewed monthly by a nurse. This review was documented on the emergency equipment inspection log.

The program has one automated external defibrillator (AED) which is located in master control. The medical staff checked the AED during the annual compliance review and it was in working order. The last six months of AED documentation indicated the nurses conducted weekly checks. The AED pads expires on May 2022 and the battery expires on September 10, 2023. A review of the last four quarters of medical drills was conducted and indicated the program completed at least one quarterly drill on each shift to include first aid care, as well as conducting cardiopulmonary resuscitation (CPR) and/or AED demonstration, annually. Five pre-service and five in-service training records were reviewed and indicated each staff had the CPR, AED, first aid, and epinephrine auto-injector training. A current CPR with AED certification was found for all licensed healthcare staff.

All five interviewed youth reported being able to see a doctor or dentist, if needed. Five staff were interviewed and indicated they are permitted to call 9-1-1 when a youth is identified with a medical emergency.

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

The program has a policy and procedures to address emergency care for the youth which includes the provisions of off-site care. The policy includes notification requirements and the completion of the Summary of Off-Site Care form.

Five youth individual healthcare records (IHCRs) were reviewed and two were applicable regarding off-site care events during the review. In both cases, the youth parental notifications were made. The Summary of Off-Site Care form was utilized to document each event and was filed in each IHCR, as well as the discharge instructions. In one IHCR, the designated health authority (DHA) reviewed and signed all off-site care findings, instructions, and information. The youth received the required follow-up testing, referral, and care as appropriate.

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

The program has a policy and procedures to address monitoring youth with a chronic condition which requires any youth with a chronic condition to receive a periodic evaluation at least every two months by a physician. During the healthcare admission to the program, youth are seen by

a nurse and any chronic conditions are documented on the admission progress note in the youth's individual healthcare record (IHCR). All youth are placed on the list to be seen by the designated health authority (DHA) on the DHAs next visit to the program. The program maintains a chronic condition roster. The roster includes the youth's name, date of admission, chronic condition, whether the youth was admitted to the program with medication, the date of the most recent periodic evaluation, and the due date of the next periodic evaluation. Youth taking psychotropic medications are placed on a separate list to be seen by the psychiatrist for medication management.

Five youth IHCRs were reviewed and four were applicable regarding a chronic condition. All four applicable records documented the youth's chronic condition on the Facility Entry Physical Health Screening form. Two youth were undergoing treatment for a physical health condition with a Body Mass Index of greater than 30. All four were classified with medical grade two through five, placed on the chronic illness list, received a specialized treatment plan, and the evaluations were tracked. Four received periodic evaluations at no greater than two months intervals.

The periodic evaluations were documented and maintained in each IHCR chronological progress notes and there was no indication of lapses in care. In all four IHCRs, the Department's Problem List was updated in accordance with the Health Services Rule. The program maintains a youth roster of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records supported each youth received periodic evaluations, as required.

The DHA reported youth with chronic conditions are evaluated every sixty days and prior to the change of psychotropic medications and no less than every thirty days when prescribed. An interview with the facility administrator (FA) and nursing staff also confirmed the practice. A nurse stated the evaluations are tracked in an internal log.

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

The program has a policy and procedures outlining the requirements for medication management and includes the process for disposal of unused medication. Five youth individual healthcare records (IHCRs) were reviewed and two youth were admitted with medications. The program provided one additional example. The three applicable IHCRs indicated the youth were taking medications at the time of admission and were verified prior to the youth being accepted into the program. The Department's Prescription Medication Verification Checklist was utilized. In all three IHCRs, the designated health authority (DHA) and the designated mental health authority (DMHCA) were notified and instructed the medical staff to continue the prescribed medication as indicated.

Four of the five sample youth IHCR's reviewed were applicable for youth currently taking medications. The medications had a current, valid order/prescription and the standard Department Medication Administration Record (MAR) was utilized to document all medication and treatment. Each MAR clearly indicated medication start and stop dates and staff initialed each medication entry as well as documented weekly side effect monitoring. In the four

applicable IHCRs, the DHA placed an order on the Practitioner Order Form when a current medication was continued, discontinued, changed, or a new one was ordered. There were no standing orders, pro re nata (PRN) orders or emergency treatment orders for psychotropic medications.

In the four applicable case, the youth's refusal to take medication was documented on the refusal form, as well as the MAR. Observations of medication administration confirmed the nursing staff maintained the Six Rights of Medication Delivery/Administration. The program's clinic was observed. All medications were stored in separate locked areas inaccessible to youth. The medication cart was clean and well organized having separate compartments for oral, injectable, topical, liquids, and controlled medications. The program maintains non-controlled medication and sharps/syringes in the locked medication cart in a locked room, as well as behind locked cabinets and in locked drawers in the clinic. All controlled medications are stored in the locked medication cart in a separate locked box. The program has a small locked refrigerator which is utilized for youth medications requiring refrigeration.

Medication pass for seven youth was observed during the annual compliance review. The medication administration occurs in the medical clinic with a half door leading from the clinic to the hallway. The medication cart was placed inside the door and the nurse stood next to the cart. Each youth was escorted to the clinic by direct care staff, the youth stood on the opposite side of the half door. The nurse's sole responsibility was to provide the medication as the direct care staff provided supervision of the youth. There were small cups of water on the medication cart. Each youth approached the cart and stated their name, the prescribed medication taking, and any allergies to the medication. The nurse consulted the youth's Medication Administration Record (MAR), retrieved the correct medication, and placed the medication in a small paper container. Each youth was provided a cup of water and the medication. After each youth swallowed the medication, the nurse had the youth cough and open their mouth using a tongue depressor and a check to ensure the youth swallowed the medication. The direct care staff also checked the youth's mouth to further ensure the youth swallowed the medication. The nurse and each youth initialed the MAR. The youth were familiar with the process and appeared to be comfortable with the process.

The nursing staff interview indicated the medication inventory is locked and perpetual and weekly inventories are maintained. The program's practice is to secure controlled substances such as narcotics using double locks on the medication cart. Five staff interviews indicated the nurse dispenses the medication to the youth. Five youth interviews indicated two did not take any medications. Two youth stated when medication is provided, the nurse will request the youth to state their name, provide the youth with the medicine, the youth drinks water, and the youth mouth is swabbed to check if the medication was taken. The remaining youth stated they received medication from the nurse.

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 for medication management which includes the process for disposal of unused medication. The procedures address the storage of medication and items defined as sharps, which includes the procedures to be used in the event there are discrepancies in the counts of medications and sharps are noted. The program securely

maintains all prescriptions medications, over-the-counter (OTC) medications, syringes, and sharps in the clinic. The patient-specific prescription medications and a working supply of OTC medications are in the locked medication cart which is maintained in the locked clinic. Medications are destroyed by two nurses and the program has a contract with a consultant pharmacist who comes on a monthly basis for monitoring.

There were weekly and perpetual counts of the sharps and the OTC medications completed by the nurses for the past six months. The inventories for the past six months were reviewed. There were no discrepancies noted. During the annual compliance review, the counts of three sharps were matched against the current inventory and all counts matched the inventory. Three OTC medications were counted and matched the current inventory. Three prescription medications, two which were controlled substances were counted and all matched the current count of the medication. In addition, the nurses were observed conducting a shift-to-shift count of controlled medications prior to the medication pass. All were verified to be accurate.

Documentation confirmed inventories with running balances are maintained on all controlled substances with a shift-to-shift inventory conducted by the medical staff and it is documented on the youth's Individualized Controlled Medication Inventory Record. The nursing staff interview indicated the medication inventory is locked and perpetual and weekly inventories are maintained as well as their practice to secure controlled substances, such as narcotics by using double locks on the medication cart.

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

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

annually by the administration of the program and included risk assessment and methods of compliance.

In all five individual healthcare records reviewed, each youth received training to include the prevention of blood borne pathogens and communicable disease to include handwashing within seven days of admission into the program. A review of the five staff pre-service training records indicated all received the infection control and exposure control training. The FA interview indicated the exposure control plan is located in the clinic.

4.18 Prenatal Care/Education	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 to address the care of pregnant youth. The policy requires the youth to be examined at certain intervals and to receive education pertaining to pregnancy, birth, and child rearing. The program provided a closed file of a youth who was pregnant since the last annual compliance review. The youth gave birth on January 21, 2020. Documentation confirmed the youth received a routine, focused medical evaluation every thirty days. Documentation confirmed an alert was placed for vital nutrition and health awareness for the youth.

The medical staff maintains a binder of education materials relating to pregnancy. A review of this binder documented all required topics including alcohol/drug use, smoking, nutrition, sexually transmitted diseases, contraception, birthing process, post-partum care, basic baby care, child/infant development, and parenting skills will be discussed with applicable youth. The program entered into an agreement with a local agency through the Healthy Start Coalition to provide education and support including information on infant care, lactation, and nutrition. The program's policy and procedures require staff to be trained in pre-natal care. The pre-service training records of five staff were reviewed. There was documentation to support five staff received training on the monitoring, observation, and emergency care of pregnant youth.

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

Documentation revealed the program is in accordance with Chapter 464 F.S,:63M-2 F.A.C. and contract requirements. Daily clinical care is performed by licensed registered nurses (RNs) and licensed practical nurses (LPNs) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management, and other assigned duties according to the Department Rule as well as facility operating procedures and nursing protocols approved by the designated health authority (DHA).

Documentation confirmed the licensed nurses are practicing within the Florida Nurse Practice Act and the applicable Florida Board of Nursing Rules (Chapter 464, F.S., and Division 64B9, F.A.C.). The program has on-site nursing coverage which is being provided by RNs or, at a

minimum, LPNs. Documentation confirmed the licensed healthcare professional providing the direction to the LPN is responsible for reviewing all medical cases daily with the LPN and be available on-call for consultation.
Documentation confirmed the nurse licensure credentials and cardio-pulmonary resuscitation (CPR) certifications are current. The program is in compliance with specific duties outlined in the contract.

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 addressing youth supervision. According to the policy and procedures provided to the annual compliance review team, staff-to-youth ratios are one staff to eight youth during awake hours, one staff to twelve youth during sleep hours, and one staff to five youth for off-site activities, visitation, or when separated from the population. However, the program's contract was amended in 2019 and staff-to-youth ratios are now one staff to six youth during awake hours and one youth to eight staff during sleep hours. Over the course of the four-day annual compliance review, observations of supervision were made each day. Staff were observed supervising youth during school hours, in the cafeteria, upon return from a youth transport, and youth movement through the facility. Staff were observed to be in compliance with the amended ratio requirement. The shift supervisor was able to give the total youth count when questioned. A video review of supervision during sleeping hours found the required staff-to-youth ratio was maintained during sleeping hours. The daily schedules were posted in the dorm and cafeteria. The program has a full schedule of activities planned and youth were observed engaged in the activities. Staff were observed escorting youth from one location to another. At no time during the annual compliance review were youth observed wandering freely about the program. Each of the five interviewed staff confirmed their understanding of the procedures when there is a discrepancy with the count. Each staff indicated the count is reconducted until the count is reconciled. Observations found the counts were conducted at scheduled and unscheduled times and the shift supervisor was able to give an accurate count when questioned.

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 policy and procedures which states the program's behavior management system (BMS) or positive performance system (PPS) fosters accountability for behavior and compliance with the residential community's rules and expectations. The PPS was observed in the dorm and cafeteria. The PPS is clearly explained in the resident handbook, which is accessible to youth. The program's PPS details the rules and the positive and negative consequences for actions. Five staff pre-service training records and five in-service training records were reviewed and indicated all staff training records contained PPS training. All five interviewed staff confirmed training and their understanding of the PPS. Informal interviews with staff during the annual compliance review week confirmed their understanding and implementation of the PPS. The orientation checklist documents the PPS is reviewed with the

youth. All five reviewed youth case management records contained a complete orientation checklist. The PPS promotes youth rights, positive and negative consequences, constructive disciplinary action, opportunities for reinforcement, positive dialogue, and peaceful resolutions as well as provides youth with pro-socially acceptable alternative behavior, maintains order and security, and minimizes the separation of youth from the population. Youth have an opportunity to explain their behavior. The PPS is connected to each youth's individual performance and treatment plan goals. The PPS includes a variety of rewards including daily snacks, boutique (point store), verbal praise, special privilege activities, and off-campus incentive trips. The facility administrator interview confirmed the PPS is a level/point system with daily and weekly incentives. Point cards and levels are reviewed by administration daily during morning management meetings. Five youth were interviewed about the PPS. Three interviewed youth rated the PPS as good. One youth rated the PPS as fair and one youth rated the PPS as very poor. All five youth stated they have a good understanding of the PPS and all five were aware of the rewards and incentives they can be rewarded for positive behaviors.

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.*	

According to the policy and procedures, the program does not utilize room restriction which was confirmed by youth and staff interviews and observations. The recreation therapist tracks weekly points earned by youth. At the end of each week, the point sheets are filed in each youth's case management record. Youth and staff interviews confirmed their understanding of the positive performance system (PPS). The facility administrator (FA) interview confirmed rewards are tracked daily and the program tracks the number of youth making their day/week in the PPS database. The FA interview confirmed consequences are monitored during the morning management meeting, as well as during special and regular treatment teams. The program's PPS does not include increasing a youth's length of stay, denial of basic rights, promotion of group punishment, or disciplinary confinement. All five interviewed youth confirmed they are never punished by other youth. Positive and negative behaviors are reviewed during treatment teams. Each of the five interviewed staff indicated they received feedback on their implementation of the PPS daily and as needed. The program's PPS includes a process wherein staff explain to the youth the reason for any sanction imposed. Youth are given an opportunity to explain their behavior and both the staff and the youth discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternative acceptable behavior. All five interviewed staff confirmed training and their understanding of the PPS and indicated there are a variety of rewards and incentives for good behavior. All five stated the PPS is discussed during staff meetings monthly.

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

The program has forty-nine cameras. All forty-nine cameras were operational at the time of the annual compliance review. Work orders, budget requests, and bids have been submitted to update the recording system which was recently completed. The video coverage is stored for thirty days. The program's practice is to conduct checks of youth in their rooms every eight to ten minutes. Video recordings and ten-minute check sheets were reviewed for seven randomly selected dates for the three dorms finding no more than ten minutes passed without the staff actively observing each youth. All check sheets contained the times and staff initials for all checks completed. Five staff were interviewed and each indicated room checks are completed every six to ten minutes. The facility administrator interview confirmed the program has forty-nine cameras with video coverage stored for thirty days. During an interview with master control, it was reported a call check is made to ensure staff complete their check on time.

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

The program's policy and procedures address census, counts, and tracking. Observations throughout the week of the annual compliance review confirmed counts were completed in accordance with the program's policy and procedures. The program tracks daily census information including the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program in the logbook. Logbooks for the previous six months were reviewed and found no discrepancies with counts or census. Informal and formal counts were observed during the annual compliance review and found they were each conducted as required. All five interviewed staff confirmed they were knowledgeable of the procedures for reconciling the count if there is a discrepancy and when emergency counts are conducted.

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

The program has a policy and procedures addressing logbook entries and shift report reviews. A review of the logbooks revealed all entries were in ink. None of the pages were removed or obliterated. Each logbook covers a one-month period. The logbook pages are pre-printed shift reports. The first page of each shift contained staff signatures, certifying staff reviewed both current and previous shift information. There were minor exceptions noted where the supervisor signed in the space allotted for on-coming staff's signatures, instead of the allotted space for the supervisor. On May 14, 2020 between the hours of 6:15 a.m. and 6:45 a.m., one line was left blank. In the front of each logbook, there is a page for documenting weekly management reviews of the logbooks. The logbook was not reviewed for the weeks of March 28, 2020, April 4, 2020, and April 10, 2020. The logbook pages documented perimeter checks, weather alerts, emergency situations, Central Communications Center (CCC) reports, shift summary notes, incidents, Protective Action Response (PAR) incidents or times when mechanical restraints were used which is not applicable for this program, transports, law enforcement or the Department of Children and Families visits, admissions and releases, youth removed from the mainstream population, escapes or attempted escapes, keys, radios, drills, Prison Rape Elimination Act (PREA) checks, fire safety, scheduled and unscheduled counts, and any calls made to the Florida Abuse Hotline and CCC. Incoming staff review the previous two shifts and the review is 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's policy and procedures addressed distribution, tracking, storage, and overall control and security of keys. A review of the inventory matched the key rings in use. The keys are stored in a secure area in master control, which is not accessible to youth. Each set of keys has an assigned key hook. Keys are assigned to staff according to their department. Restricted keys, temporary keys, and visitor keys are all stored separate from each other. There were no reports of broken or damaged keys. The Department is in the process of having new keys made due to a shortage of keys. There were no incidents of lost keys, which was verified by the review of internal incident reports and Central Communications Center (CCC) reports. A random check of three staff key rings confirmed the keys matched the inventory. The physical plant manager is responsible for replacing broken or damaged keys. Informal interviews with staff confirmed staff's knowledge of the key rings and assigned keys. All observations during the annual compliance review found personal keys were secured and staff were aware of program keys in their possession. Key control logs documented the issuance and return of keys on a consistent basis. All five interviewed staff confirmed staff knowledge of and implementation of

key control policies and procedures. Additionally, staff reported if keys were damaged, they would notify their supervisor and submit a maintenance request. An informal interview with the master control operator indicated assigned keys are only assigned by the facility administrator, restricted keys are stored apart from non-restricted keys, and only assigned staff can access restricted keys. Master control tracks keys as they are signed out and signed back in by staff prior to receiving their personal 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 system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and youth, which is clearly explained in the program's policy and procedures and resident handbook. The policy also states any staff who is found in possession of contraband in a program will be subject to disciplinary action up to, and including, dismissal, as well as procedures regarding notification of law enforcement for items considered illegal as defined in Florida Statutes. The program defines items and materials considered contraband when found in the possession of youth, provides youth with a list of contraband, and informs youth of the consequences if found with contraband. The prohibited list includes personal cell phones and/or equipment and/or electronic devices capable of taking pictures and/or audio/video recordings, which are prohibited in the secure area. Staff and supervisory staff were able to explain the contraband procedures. The contraband notice is posted on the front gate and states law enforcement will be contacted for anyone bringing in contraband. This practice was confirmed through an interview with the facility administrator (FA). The FA stated contraband would be logged into a binder for reference and illegal contraband if brought into the facility would result in law enforcement being called for disposal. All searches are documented in search binders (visitation, room, and youth). The binders were reviewed and found searches were documented appropriately. There were no incidences of introduction of contraband documented during the annual compliance review period.

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

The program has a policy and procedures addressing searches. Observations during the annual compliance review found searches were completed prior to and after movement from one area to another. Observation of a transport indicated searches were completed according to policy and procedures. Observations found searches were conducted in a manner which treated the youth with dignity and respect. Searches were conducted in accordance with Protective Action Response (PAR) training manual. Five interviewed youth indicated searches are competed after every movement, off-campus trips, outdoor activities, when items are missing, after visitation, and after meals. Five interviewed staff reported searches are conducted before and after every movement.

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

The program has two vans. Both vans are currently in use and had an annual safety inspection. No deficiencies were found during the annual safety inspection. Both vans were observed to be secured when not in use. The two vans used for transports contained a fire extinguisher, seat belt cutter, window punch, and appropriate number of seat belts. Each van had an assigned first-aid kit and suicide kit which is stored in master control. An observation of a youth transport indicated both staff and youth wore seatbelts, doors are secured from inside accessibility, and there is a safety screen separating the main cabin from the driver. A check of all personal vehicles in the parking lot found all vehicles were locked.

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's policy and procedures were reviewed and found to ensure compliance of all requirements outlined by the Department relating to transportation of youth and driver eligibility. An observation of a transport occurred and indicated staff of the same gender completed the transport. Two staff and one youth were on the transport. The youth was transported with mechanical restraints. A check of all personal vehicles in the parking lot found all were locked. An approved driver list was observed to be posted in the master control with staff who have current valid driver's licenses. The transport binder was reviewed. All transport orders were filled out and documented searches and vehicle's safety, ratio maintained during transports, cell phone, first-aid kit and suicide kit, and transporters of same gender as youth. Five interviewed staff confirmed youth are not transported in staff's personal vehicles, staff reported they are issued a facility cell phone and radio during transports, staff reported they will take a first-aid kit with a suicide kit on all transports, and the vehicle is searched prior to the transport for

contraband. Staff indicated they are to maintain a one staff to five youth ratio; however, transports always have a minimum of two staff. Transporting staff were able to explain what they are required to do in the case of an emergency. Five youth were interviewed on transports; however, due to the COVID-19 pandemic none of the youth had been on a transport since arriving at the program and, could not comment on contraband procedures or the safety of transport.

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

The policy and procedures designate the physical plant manager as the person responsible for conducting the weekly safety and security audits. The weekly safety audits are maintained in a binder, which was reviewed. During the annual compliance review period, there were no inspections missing. The forms documented safety and maintenance repairs needed and the date and time the repairs were completed, or due to be completed. The program has documentation of on-going efforts to get extra keys from the Department. All forms were reviewed and signed by the facility administrator (FA). The forms cover radios, cameras, keys, telephones, mechanical restraints, the generator, flashlights, fire safety equipment, alarms, ensuring no anchor points, youth rooms, recreation area, grounds, correction action needed, and corrective action completed. The interview completed by the FA confirmed the weekly safety audits are conducted in accordance with program policy and procedures.

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 policy classifies tools as class A and class B tools, with class A tools having sharp edges and/or considered more dangerous, and class B tools being cleaning items such as mops and brooms. All observations during the annual compliance review found all tools were secured when not in use. Class B tools were in secured closets. All class B tools matched the inventory. Class A tools are stored in the kitchen in a locked cabinet in the food manager's office and in the maintenance area; both areas are not accessible to youth. The class A tools are on shadow boards and are inventoried. The inventories were reviewed and were complete. A random check of class A tools in the kitchen and in the maintenance area was conducted and found all items matched the inventory lists. The physical plant manager indicated there have not been any reports of damaged or dysfunctional tools. Five staff were interviewed and indicated youth are only allowed to use class B tools such as a broom, mop, and scrub brush. Five youth were interviewed and confirmed the only tools they have used are mops and brooms.

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

The program has a policy and procedures in place to ensure youth use tools safely and are supervised appropriately to prevent injuries to the youth, peers, and staff. The orientation checklist addresses the use of tools and training on the use of tools. Five youth records were reviewed and each record contained a completed orientation checklist. Staff were aware the

policy forbids disciplinary work projects for youth. Youth do not participate in vocational activities requiring the use of tools. Youth risk assessments for off-campus activities and use of class B tools are maintained in a binder. The binder was reviewed and all forms were completed according to the program's policy and procedures. Each of the five interviewed youth confirmed the youth use scrub brushes, mops, and brooms. All five interviewed staff confirmed youth use mops and brooms.

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

The program has a policy and procedures addressing when an outside contractor or worker enters the program to perform a work project requiring the use of tools. The program restricts tools to those necessary, checks tools upon the worker's arrival and departure, restricts youth access to the work area, ensures immediate reporting of any tool the worker cannot locate, and follow-up if any tool is missing. Personal cellular phones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area. The program's policy and procedures outline who is responsible for providing approval/permissions if such items are required. The program maintains a binder which contains all notice of tool equipment instructions forms, which the outside contractor must sign. The binder was reviewed. The dates of the work invoices matched the sign-in sheets of the outside contractors. The tool notice forms also addressed tools checked upon arrival and departure, tool restrictions while in the facility, youth being restricted from the work area, and missing tool follow-up. Outside contractors are required to sign the notice of tool equipment instructions form.

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

The program has policy and procedures which states drills are conducted in accordance with the program's disaster plan or Continuity of Operations Plan (COOP) and facility operating procedures. Fire drills are conducted monthly on each shift. The program has been operating on two, twelve hour shifts for the past nine months. The drill documentation included the type of drill, date and time of the drill, participants, brief scenario, and findings/recommendations. Fire evacuation routes and egress plans were observed to be posted throughout the facility. The program has conducted fire, safety, evacuation, and disaster drills during the past twelve months, in accordance with the COOP except for July which was missing one drill. All five interviewed youth were aware on what to do in case of fire and have participated in a drill. All five interviewed staff reported they participate in the following drills such as weather, bomb threat, escape, fire, medical, riot, and suicide. The facility administrator reported fire drills are conducted monthly on each shift and COOP drills are conducted quarterly on each shift.

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

The program has a policy and procedure which states the Continuity of Operations Plan (COOP) is located in master control and administration. The plan addresses alternative housing plans approved by the applicable Department regional director/designee. The COOP addresses fire prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The program conducts COOP drills on each shift. The drill documentation included type of drill, date and time of the drill, participants, brief scenario and findings/recommendations, and pictures. The drills included escape, missing tools, fire, and evacuation severe weather. The program has food and necessary supplies readily available in case of emergency evacuation. The program maintains an administrative hard-copy files on youth in case of emergency with all required information located in the COOP binder. The facility administrator reported the COOP is in master control and administration which is accessible to all staff.

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 for the storage and inventory of flammable, poisonous, and toxic items and materials. Chemicals are secured and inventoried as outlined in the program's policy and procedures. All chemicals were observed to be secured during the annual compliance review. The flammable items are stored in a locked cabinet behind a locked door, in the sally port. Cleaning chemicals are in locked closets in the kitchen. Inventories in each area were reviewed. The inventory in the maintenance area was accurate. The inventory in the kitchen closet was current and up-to-date. Staff and youth interviews confirmed youth do not use or have access to chemicals. Safety Data Sheets (SDS) were in each area where chemicals were stored in a binder with a matching picture of the chemical. The SDS matched the chemicals in each storage area.

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

The program has policy and procedures which states the program maintains strict control of flammable, poisonous, and toxic items and materials. The program policy and procedures indicated youth are not allowed to or have access to chemicals. Observations throughout the annual compliance review confirmed youth do not use or have access to the chemicals. Five youth were interviewed regarding the use of these materials. Each of the five interviewed youth reported they do not use any chemicals. All five interviewed staff reported youth do not use chemicals.

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 addressing the disposal of flammable, toxic, caustic, and poisonous items are in accordance with Occupational Safety and Health Administration (OSHA) Standard. The policy and procedures identify program positions, titles, or functions authorized to dispose of these items. The physical plant manager is responsible for the disposal of all hazardous waste and/or solid waste and has received training for disposing hazardous items and toxic materials. The physical plant manager has not had to dispose of any chemicals other than dirty mop water which can be poured down the drain. The program does not use grease for cooking on-site. The physical plant manager indicated if waste had to dispose of, the physical plant manager would take it to the county's hazardous waste site. The facility administrator reported waste is disposed of safely, using an approved vendor or waste station and the item will be documented to include the way it was disposed.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has policy and procedures to allow visitation and communication for youth while in the program. The visitation procedures are posted on the front gate and on the wall in the lobby. The visitation and communication procedures are covered in the resident handbook and addressed on the orientation checklist. Each of the five interviewed youth confirmed they have opportunities to contact their family by telephone, mail, and during visitation but have not had visitation for several months due to the COVID-19 pandemic. The visitation schedule was posted throughout the program; however, due to the COVID-19 pandemic, visitation has been postponed. The program offered extra telephone and video calls utilizing Zoom, FaceTime, and Skype. The visitation, telephone and correspondence logs were reviewed. The logs indicated prior to the COVID-19 pandemic, youth had contact with only approved persons. Incoming and outgoing mail is searched and recorded in the correspondence logs. There were no youth applicable for a history of human trafficking; therefore, the program is not required to request

clarification from the youth's juvenile probation officer (JPO) about any parent/guardian past or current human trafficking investigation involvement.

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

The program has a policy and procedures for the search and inspection of the controlled observation room. The program utilized controlled observation eleven times in the past six months. The rooms used for controlled observation meets all the requirements. Three controlled observation reports were reviewed. In all three reports, staff documented an inspection of the room and a search of the youth before the youth was placed 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 has a policy and procedures for controlled observation. Three controlled observation reports were reviewed. In all reports the supervisory or higher-level staff authorized placement. In all instances, the youth were displaying active aggression, violent behavior, physically out-of-control, and staff advised the youth the reason of placement in controlled observation and expected behavior for removal. In all three reports a healthcare professional or staff of the same gender as the youth completed the health status checklist. In one of the three reports, the youth was in controlled observation for two hours and fifteen minutes. The assistant facility administrator or designee granted an extension every 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 has a policy and procedures for controlled observation safety checks and releases. Three controlled observation reports were reviewed. In all three reports the staff making the placement completed the first page of the controlled observation report and submitted it to a supervisor. Staff documented safety checks at least every ten minutes and observations of the youth's behavior. Staff documented all safety checks and observations on the controlled observation safety checks form. The facility administrator (FA) or designee who has delegated authority gave written approval before the youth was released from controlled observation in all three reports. The controlled observation report, health status checklist, and controlled observation safety checks were maintained in an administrative file. The assistant facility administrator (AFA) or designee reviewed and approved all three controlled observation reports within fourteen days of the youth's release from controlled observation.